S. HRG. 110–34

THE FISCAL YEAR 2008 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

FEBRUARY 13, 2007

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THE FISCAL YEAR 2008 BUDGET FOR VETERANS' PROGRAMS

TUESDAY, FEBRUARY 13, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room SR–418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Brown, Tester, Webb, Sanders, and Craig.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order. Aloha, and welcome to all of you who are here. I look forward to our dialogue with Secretary Nicholson and other top VA officials, as well as the representatives of all our Veterans Service Organizations here with us today.

I also want to say that I am so delighted to be here with my colleague and friend and former Chairman of this Committee. We have worked so well together, and I look forward to continuing that relationship for the benefit of the veterans of our country. I am so happy to be working with him again.

At the outset, I am pleased that the Administration is requesting a straightforward increase for VA, without some of the offsets proposed in prior years. While some see this proposed budget as good, others see it as inadequate. I believe that what we need is a much better understanding of some of the specifics before our Committee goes forward to the Budget Committee with our views and estimates.

For example, I believe we need to know what the actual increase is for veterans' health care in the proposed budget. It appears to me that inflation and automatic cost increases account for nearly all of the $1.9 billion increase being requested of Congress. This would leave little funding available for expansions or improvements to key programs such as mental health and care for returning servicemembers. I will address this concern in my questions to VA.

I want you to know that I remain committed to my opposition to the policy proposals that would impose higher costs on veterans.

Once again, the Administration is suggesting that we ask veterans to pay more out of their own pockets if they are not disabled but still want access to VA care. Let me be clear about these vet-

erans who would be forced to shoulder these cost increases. Many of these veterans cannot, in my view, be characterized as "higher income." These are veterans living in places like my home State of Hawaii, where the cost of living is one of the highest in the country, who make as little as $28,000 a year and would be asked to pay new fees for their care or their medication.

I have a number of questions about this year's enrollment fee proposal. Basing the fee upon family income is a different version than the Administration has proposed in the past. I am concerned about the lower end of the tier structure, those working families with a combined income of $50,000 a year, and how this policy would affect them. A family with two-veteran wage earners, each taking an average number of medications and each paying the enrollment fee, would have to pay nearly $3,000 more in out-of-pocket costs if the proposed fees are mandated. I do not believe this is the way to reward the working families who have served our country.

On the benefits side of the ledger, VA must be ready to adjudicate claims in a timely and accurate manner. Should VA receive claims in excess of the 800,000 that are estimated for next year, I do not believe the Department will have the resources to handle the workload. In addition, VA does not have a history of absorbing the impact of new court decisions easily, and I am concerned that pending court cases may have an adverse effect on VA's timeliness and accuracy.

We also know that the ongoing situations in Iraq and Afghanistan are increasing VA's workload and will continue to do so for many years to come. The time for VA to hire and train staff to meet present and future demand for timely adjudication is now.

I will continue to monitor VA's inventory and staffing requirements. Our Nation's veterans deserve nothing less than having their claims rated accurately and in a reasonable amount of time.

I am committed to working with the Secretary and my colleagues on both sides of the aisle to ensure that the Department gets what it truly needs to deliver the highest-quality benefits and services to those who have served.

I am also deeply committed to working to have all of our colleagues in Congress recognize the reality that meeting the needs of veterans is truly part of the ongoing costs of war.

Mr. Secretary, I want to share that, prior to this hearing, staff asked some questions about the various proposals included in this budget. The day after the budget roll-out, basic questions were posed, such as: Would there be a cap on total drug copayments imposed on veterans? We did not receive this information. I cannot emphasize enough that answers must be provided in a more timely way.

Again, I want to say welcome to all of you here today, and, Mr. Secretary, I want to wish you well. As I told you, we look forward to working together for a great year and in years to come for our veterans. We do this on behalf of the Nation's veterans in the weeks and months ahead, as the Committee works to put together the best possible budget for veterans' programs in the coming fiscal year.

Now, I would like to call on our Ranking Member, Senator Craig, for his statement.

STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER, U.S. SENATOR FROM IDAHO

Senator CRAIG. Well, Mr. Chairman, thank you very much, and I think your concluding words are the most important—"the best possible budget" we can possibly arrive at for our veterans.

And, again, let me thank you, Mr. Secretary, for appearing before the Committee this morning. I know that it has been difficult to put a 2008 budget together in the absence of a 2007 budget. I think we will have that out for you this week. But where is the level of spending? And I think that is a concern. I would say, though, that working with all of my colleagues on this Committee and the Appropriations Committee staff, I think—in fact, I believe in an absolute certain way that you will be pleased with the 2007 budget, as will millions of veterans who rely on VA's services, because I think this Congress has been responsive.

Today, you put before us another strong funding recommendation for the upcoming fiscal year. Within the context of the total Federal budget request for Fiscal Year 2008, veterans are again, in my opinion, clear winners. Let me give a visual demonstration of this fact.

On the chart behind me, you will see that when discretionary spending increases associated with defense- and homeland security-related spending are factored out, there is an $8 billion increase left over for all other Federal agencies and programs. Of that $8 billion, under the President's plan, about $3 billion will go to VA. In effect, this will leave about a 1 percent increase for the rest of Government. As I said, the President and the Congress continue to make veterans a priority within the overall Federal budget.

Unfortunately, I have read or heard a number of statements from some of my colleagues suggesting that this President has demonstrated a lack of commitment to VA funding. This rhetoric persists even in the face of a VA budget that has increased 77 percent—let me repeat that—a VA budget that has increased 77 percent under President Bush's watch. Where was the strident criticism during the late 1990s when, in 2 consecutive years, actual cuts in VA medical care were proposed by then-President Clinton? Why now are 10 percent average annual increases bemoaned as inadequate, but 2 percent increases during the Clinton years were hailed as an essential to control Federal spending and reduce the deficit? Frankly, I find that double standard very troubling.

In the past, I have spoken at length about impending collisions between VA spending and the spending of other Federal programs. Well, as the chart demonstrates, the collision is upon us, except it does not resemble a collision at all. It, rather, resembles the VA in an 18-wheeler headed down the Federal road and running over the top of other agencies in its process.

Now, that is an interesting and probably a colorful metaphor. It begs the question. Can this pattern be sustained? That is the question that I and my colleagues will grapple with as we debate with you, Mr. Secretary and the President, the President's budget in the months ahead.

One of my favorite sayings is attributed to Benjamin Franklin. He said, "The definition of insanity was doing the same thing over and over but expecting different results." Well, it appears that the

Administration has heeded Ben Franklin's wisdom with the Fiscal Year 2008 VA budget in three key areas, and I commend the President for listening to his critics on these issues, and I would hope we could shift some courses. This President has shifted courses.

First, as many already know, it is the sixth year in a row that some form of increased cost sharing on veterans with higher incomes and no service-connected disabilities is being proposed. The Chairman has just mentioned it. Each year, the proposals were essentially dead upon arrival. We all know that. There was not a Congressman or a Senator who wanted to support them. Members of the veterans organizations alike argued that Priority 7 and 8 veterans were not wealthy and that an enrollment premium would drive veterans from the system because they simply could not afford to pay it.

In response, this year the President's budget proposes a tiered premium that only applies when the income of a non-service-connected veteran hits $50,000, double the income floor of previous proposals, and above the median income level in the United States. The Chairman of the MilConVA Subcommittee of Appropriations now, she and I had that discussion a year ago and recommended to the Administration that if they came back to us with the same proposal, it would go nowhere. They have not. They have substantially adjusted and changed it.

Second, many complained that the priority proposals forced one veteran to pay for the health care of another, and that relying on future premium collections to reduce appropriated dollars was a risky way to fund a health care system. This year, the President proposes exactly the opposite. He recommends that new revenues generated by his proposal be deposited directly in the Federal Treasury, no tradeoffs, and not used as an offset against appropriated dollars. In other words, the President's medical care appropriation request is not affected by or dependent upon the Congress' action on his fee proposals.

And, finally, past budgets by both Republican and Democratic Presidents have been criticized for their use of unspecified management efficiencies that were driven primarily by OMB's directives to reduce the need for appropriated dollars. This budget ends that practice.

Let me talk for a moment, Mr. Chairman, about my own view of the President's proposals. I know many Senators have come out once again against the President's premium proposals in this budget. I, on the other hand, am one that finds these premiums to be a very reasonable price for access to what is widely now hailed as the best health care system in America. I would like to take a minute to go back in time to the late 1990s when the VA first began the transformation from a hospital system to a health care system. And as we know, those approaches are very different.

From about 1999 on, the VA started to see hundreds of thousands of new enrollees every year. Interestingly enough, an overwhelming proportion of those new enrollees were Medicare-eligible vets from World War II and the Korean War. In fact, today over 45 percent of the 5.5 million users of VA's health care system are Medicare eligible. Many of them signed up for VA care to get access primarily to one thing: the drug benefit.

Of course, at that time Medicare Part D was not an option for them. Now it is. As enrollment accelerated, long wait times began to appear. Using authority given by the Congress to focus limited resources on the VA's highest priority patients, then-Secretary Tony Principi closed enrollments to new Priority 8 veterans. As a result of all of this, I find myself in a bit of a quandary. The VA now provides care to 2.5 million veterans who have access to Medicare and nearly 550,000 who have TRICARE coverage and 215,000 who have both TRICARE and Medicare. That may be well and good, but it probably is not efficient, and it certainly does not appear fair to those Priority 8s now locked out of VA with no insurance coverage at all.

I often talk of those Priority 8s who, for purposes of this discussion, I call the "Boise Cascaders." Now, that may sound confusing to all of you. These are veterans in their late 40's and 50's who once worked for Boise Cascade Corporation, home-based in my State of Idaho, a forest products company. Unfortunately, the decline in the timber industry in the country shoved them off the rolls of a large company's health care plan. They are now working in small businesses—construction, electrical work, local stores, et cetera—and they cannot afford health care insurance on their salary, and their employers do not provide it.

The chart behind me shows what the average cost of an individual health care insurance premium is in this country today, and that is $4,242. This is what a Boise Cascader—and there are many of them across the Nation as our economy adjusts and changes—is forced into paying.

The President's proposal may be showing us an opportunity to offer VA health care at an affordable price to those who cannot offer it to themselves at a time of their need. I cannot think of anyone with a family income of at least $50,000—and that is what the new proposal is—and without any other health care insurance who would not suddenly drop VA health care because all of a sudden it cost them $21 per month. Now, that is $21 per month to access the number one health care delivery system in the country. By anybody's guesstimation, Mr. Chairman, that is a flat bargain.

Perhaps some with other health insurance would choose not to pay multiple premiums for multiple plans, and if so, so be it. I think it is an opportunity for us to take a segment of America's workforce that is underinsured or uninsured today and to allow others who have three options—Medicare, TRICARE, and VA—to determine which of those options they would choose to access.

So in the end, Mr. Chairman, I believe we have a strong budget request for VA with thought-provoking proposals. I note with interest that VA's request for medical care when all sources of revenue are included even exceeds the recommendation made by the Independent Budget. And as you know, Mr. Chairman, the last several years we have always heard that as a comparative.

I am sure our VSO panel will have more to say on this point, but I have said before that the care of America's veterans continues to be a clear funding priority of this Congress and this President, and I think this budget reflects it. And within the VA's budget, the needs of our veterans returning from Iraq and Afghanistan, the disabled, the poor, are front and center, where they belong.

Mr. Chairman, I have spoken long enough. You have been very patient. I think these are important issues to make. They will go on in the debate over the next several months as we work this budget out. I look forward to hearing from the rest of my colleagues and the witnesses before the Committee today.

Thank you.

Chairman AKAKA. Thank you very much, my colleague, for your statement.

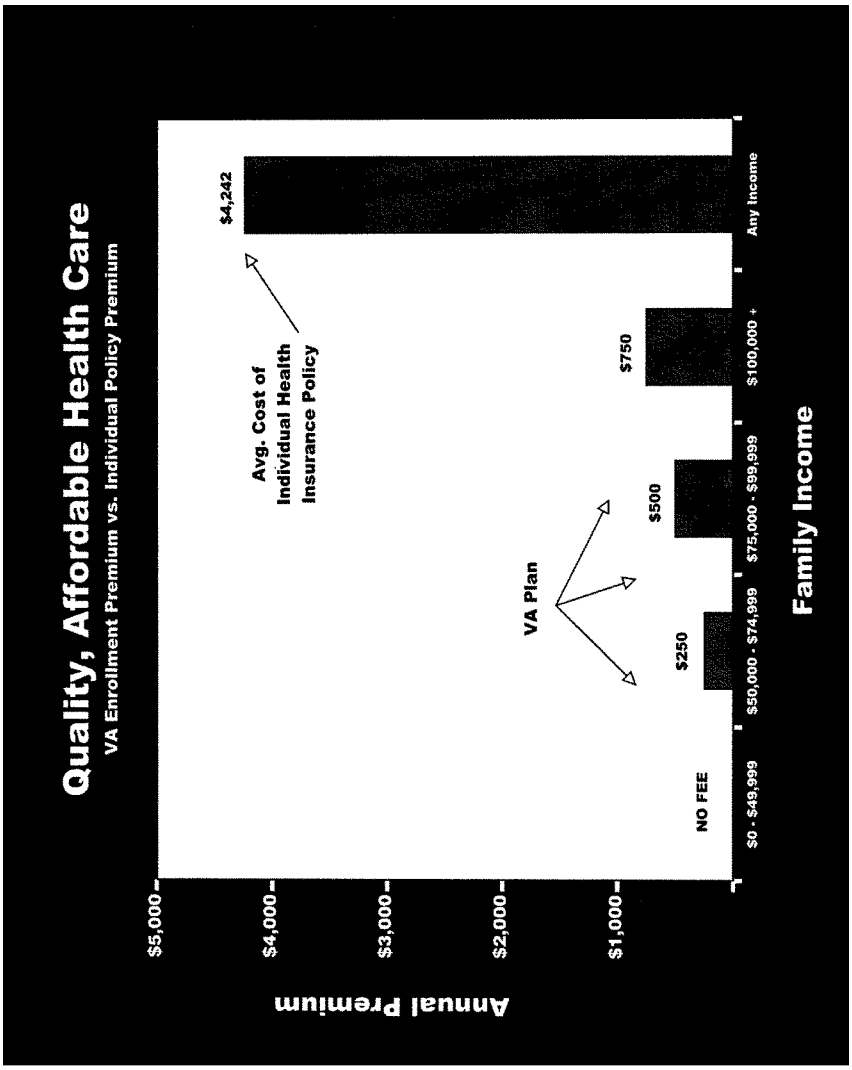
[The Fiscal Year 2008 Discretionary Budget Request, and the Quality, Affordable Health Care charts follow:]

FY 2008 DISCRETIONARY BUDGET REQUEST

(excludes defense and homeland security-related spending)
Billions of Dollars

	FY2007*	FY2008*	2007-2008 (change)
VA	$36.2	$39.2	+$3 (7.7%)
All Other	$367.8	$372.8	+$5 (1.3%)
Total	$404	$412	+$8 (1.9%)

* estimates


Quality, Affordable Health Care
VA Enrollment Premium vs. Individual Policy Premium
Annual Premium
$5,000
$4,000
$3,000
$2,000
$1,000
Avg. Cost of Individual Health Insurance Policy
$4,242
VA Plan
NO FEE
$250
$500
$750
$0 - $49,999
$50,000 - $74,999
$75,000 - $99,999
$100,000 +
Any Income
Family Income

Let me call for opening statements on Members of this Committee. I want to welcome the Members of the Committee here, and we will begin with Senator Jay Rockefeller.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I have to go do an Aviation markup right after my statement, for which I genuinely apologize. It is a classic case of cross-scheduling, which always hurts somewhere.

Mr. Secretary, I am very glad that you are here. I wrote a letter to Jim Altmeyer the other day and mentioned you. And I am also very aware of what Senator Craig has said most clearly, and that is that there has been a 77 percent increase since the President took office. And I will agree that that sounds dramatic. There is a whole variety of ways of taking that and breaking it down and seeing it in other ways. But that is not for the point here.

I think our Members would care to understand that life is not always what is the percentage of increase but, rather, are people getting taken care of the way they should be taken care of? And if you are looking at a budget, obviously everything is in the realm of possible. But it really should be—in terms of veterans, it is different from other budget item. Are they getting the health care they actually need and deserve?

My sense is that this budget does not do that. The Independent Budget suggests that VA health care needs an additional $2 billion for fully funded care. The VA has seen an enormous increase in workloads, and health inflation is real. But we have to focus on the challenging needs of our veterans returns from Iraq and Afghanistan, and I would dispute some who would say that they are getting all that they need.

I visit with them constantly, as I have discussed with Patty Murray on a number of occasions because I think Patty is passionate about veterans, and I think she deserves the credit for restoring $1.3 billion to our veterans' health care budget last Congress. But, you know, we have got Iraq veterans, we have got Afghanistan veterans, we have got World War II, Korea, and Vietnam veterans. They served, all of them, and they all deserve their benefits.

I worry that the VA continues to propose new fees to either drive veterans away from VA health care or make them pay more. One of the previous speakers indicated that we added on an extra fee in the past. But that was for a new program, for something called long-term care, which had never existed in the history of this country before and which was done by Senator Specter and myself and Lane Evans in the House before some were even on this Committee. So there was a reason for that fee increase—a new program, entirely new program. Still it is the only long-term care program in this country.

I think this year's proposal is even more discouraging about fees because the budget suggests that enrollment fees go to the Treasury general revenue. People can try to make that look good or somehow as a responsible thing to do. I do not understand that type of thinking.

Whenever I can, which is about every other weekend, I spend 3 to 4 hours in the afternoon usually with returned Afghan and Iraq veterans. They are young. Sometimes they go back to the Vietnam War, but not usually. Most of them are wounded. I do not see them at Walter Reed. I see them in West Virginia. And so I see them when they are in the course of their VA rehab and PTSD care along with the rest of it. There is no staff. There is no press. There are no pencils, no paper. Nothing goes outside the room. And these have been very, very powerful, emotional events for me, one after another after another. There are a lot of cases that come out of that which make me think of our VA budget.

I think it is really important to be honest about information, not just percentage increases but what is actually being done, what do people get, what do they not get. I think we also need a better process. I am quite pleased that the joint continuing resolution has a $3.6 billion increase for VA health care for the rest of this fiscal year. But this increase is 4 months late. As the Secretary knows only too well, such delays are hard for VA centers, especially not staffing decisions.

As I indicated—this is about a quarter of what I wanted to say—I have to do an Aviation markup and, unfortunately, I have to Chair it. So I have got to leave, Mr. Chairman, and I apologize for that. But I just think we have to be very, very careful when we are talking about veterans, number one, that we do not get political. Whether President Clinton did or did not do something is not particularly relevant to me, or whether President Bush did or did not do something. But the only test that counts here is: Are they getting the services, the medical services they need? The deep degree of distress of our veterans is almost impossible to describe the hurt, and you do not see it, and you do not get until you have been with them for several hours. And then somebody starts going really deep in describing his or her hurt, and then other members who are there, 12 or 13 gathered around in a circle, they say, "Stop, stop, stop. Don't go there. That is too painful for me."

Now, are we dealing with that? Are we not? Are we dealing with it adequately? Are we not? I think that is the only question that counts.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Akaka, Senator Craig. I appreciate your holding this very important hearing on the President's budget proposal for Fiscal Year 2008. I want to thank the Veterans Service Organizations who are here as well today, who put an awful lot of work into crafting the Independent Budget, and I think it is very important we hear what they have to say. So I appreciate them being here.

I want to welcome back Secretary Nicholson again. Mr. Secretary, as I said to you privately before we started, thank you so much for the new CBOC in Northwest Washington, the new Vet Center in Everett. These are issues we have been working on for

a number of years, and our vets in northwest Washington are really pleased that someone is finally moving the ball forward. And I do want to thank you for that publicly.

Mr. Chairman, with our troops fighting overseas and more veterans being created each and every day, it is critical that we do everything in our power to make sure that the budget we provide provides for our veterans. In the past, the VA has been dramatically wrong in its budget projections, and I think we all agree we can never let that happen again.

Mr. Secretary, you and I both agree that the VA's health care system is among the best in the country, once you get in the door, and that is what concerns many of us. It is the problem of getting in the door that we have to make sure we are addressing.

I am very concerned that the budget that we are looking at closes the VA's door to thousands of our Nation's veterans. It does, as has been talked about, include new fees and increased copays that will discourage veterans from accessing the VA, and it continues to bar Priority 8 veterans from enrolling in the VA health care system.

I am also very concerned that the VA is still underestimating the number of veterans from Iraq and Afghanistan that will seek care in the VA. In Fiscal Year 2006, the VA underestimated the number of patients it would see by 45,000. For the current fiscal year, 2007, the VA has been forced to revise its projection up by 100,000 veterans. Now the VA is projecting that it will see 263,000 Iraq and Afghanistan vets in 2008, but I am being told by some that the VA should actually be preparing to care for more than 300,000 returning veterans. Frankly, I think it is very important that we do not underestimate this number. We have seen the past failures in the VA to accurately project the numbers, and I think it is important that this Committee get it right.

While this budget increases funding for the VA over previous years, as we have heard, it does barely keep pace with inflation and other built-in costs, and it falls far short, as we will hear from the Independent Budget recommendations. This budget assumes cutbacks in veterans' health care in 2009 and 2010, and I think we need to focus on that, Mr. Chairman, because we cannot project out the care of some of these veterans in the short term. We have to make sure they are covered in the long term, and this budget does not do that.

This budget also assumes a decrease in the number of inpatient mental health patients. When all signs everywhere point to an increase in need, when the President has now proposed a surge of troops to Iraq, when the men and women in uniform are being deployed for their second and third tours of duty, and when more and more of our troops are coming home with PTSD and mental health care needs, I do not understand how the VA can assume that they will treat fewer patients for inpatient mental health care.

Mr. Chairman, I think our veterans deserve a better budget than has been presented to us. They deserve a budget that is based on real numbers and real needs. We all know too well what happens when the VA gets shortchanged. It is not bureaucrats in D.C. that suffer. It is the men and women who have served us so honorably that pay the biggest price, and I hope that, through strong oversight of this Committee and your leadership, we will make sure we

are presenting a budget that does reflect the needs that we have in front of us.

Thank you.

Chairman AKAKA. Thank you very much, Senator Murray.

May I call on Senator Bernie Sanders.

STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you very much, Mr. Chairman. And, Mr. Secretary, welcome. Thank you for being here.

Let me begin by concurring with many of the remarks made by others who have already spoken, and let me just start off by commenting a little bit on my friend Senator Craig's remarks about the very significant increase in the last several years. There are two reasons for that. Number one, as we all know, the cost of health care is soaring in every area of our lives, so if nothing else were happening, the cost of health care is going up. And, number two, we are at war, and more and more of our soldiers are coming back wounded, and they need care. So I think those factors have got to be included when we look at the increased in VA spending. But the issue that we should be focusing on, as others have said, is— is the amount of money that we are spending adequate to take care of the needs of the men and women who are the veterans of this country?

And I would hope, Mr. Chairman, that there is no disagreement on this Committee. I know that we have different political philosophies here, but I would hope that there is no disagreement that when a man or woman puts his or her life on the line to defend this country, whether it is a war that I support or I do not support, that we all agree that when that person comes home, they are *entitled* to all of the health care they need for the rest of their lives; that, in other words, when the Congress votes to send people to war, that we understand that the cost of war is not just the tanks and the bullets, but that the cost of war is that 90-year-old soldier who may have fought 50 years ago and was hurt, and that we are not a serious country, a moral country, if we ever turn our backs on any of those soldiers. I would hope that there would be agreement on that.

Sadly, for a number of years—and I think it is without dispute—the budgets that President Bush has sent us have been totally inadequate, and the evidence is pretty clear, because in Vermont, and I think all over this country, there are waiting lists for people to get into the VA. There are staffing shortages. There are, very clearly, backlogs in terms of the processing of the claims that veterans bring forward. I do not think there is a disagreement to that, Mr. Secretary. Maybe you will speak to that in a moment. But when a veteran puts in a claim, they should not have to wait 6 months or a year to get that claim adjudicated. You know as well as I do that there are veterans who absolutely believe that one of the reasons for that is maybe they will die, and then the VA will not have to pay out the claim. I do not want one veteran in the United States of America to hold that view.

Also, I would concur with the Chairman and others to say that when people put their lives on the line, we should not be asking them to pay substantially more—almost double—for prescription

drug fees. We should not be increasing the fees for people to get into the VA, which, in my view, has the designed purpose of pushing people out of the VA health care system altogether. We should be welcoming people into what some have referred to as one of the great health care systems in the world, not pushing them out.

We all know—and I want to thank all of the veterans organizations for the excellent work that they have done, and I think the Independent Budget that they have given us is a very important document. It enables us to go forward in assessing the needs of veterans from the perspective of the veterans themselves. And I appreciate very much what they have done, and this year's Independent Budget reveals that the Administration's proposed budget is about $4 billion short—$4 billion short.

Now, Mr. Chairman, those of us in the Congress know that there are many competing funding priorities. Four billion dollars is, in fact, a lot of money, but let's see how within the Bush budget that $4 billion competes with other needs that the President has brought forward. And I want everybody to hear this because this is really what this whole debate is about. It is about priorities. It is about how strongly we really care about people who put their lives on the line compared to others.

In the President's budget, he proposes the elimination of the estate tax. This tax cut benefits only—the only beneficiaries of that repeal are the wealthiest two-tenths of 1 percent of the American people; 99.8 percent of Americans do not benefit one nickel from the repeal of the estate tax. Eliminating the estate tax will save one family—the Walton family, who owns Wal-Mart, as we all know—over $32 billion. Mr. Chairman, one family, the repeal of the estate tax will benefit $32 billion. And I would like anybody in this room to tell me that as a Nation we cannot come up with another $4 billion to protect the men and women who have put their lives on the line defending this country when we can come up with $32 billion for one family. One family. This Nation is the wealthiest nation in the history of the world. We have the funds to take care of our veterans.

Mr. Chairman, I have to say that one of the most glaring—and Senator Craig raised this issue, and maybe we can work together on this issue—examples of the abandonment of our veterans is the bar on Category 8 veterans. Since 2003, this Administration has closed the door to VA enrollment by new Category 8 veterans. Estimates are that over a million veterans have been denied access to care as a result.

Now, these are "wealthy" veterans. Let us be clear. These are not the Walton family "wealthy" veterans. These are people who, if they are single, earn $28,000 a year. They cannot get into the VA anymore. We cannot take care of them, but if you are the Walton family, we have got $32 billion to take care of you.

Mr. Chairman, in my view, we should take a very, very hard look at this budget. In my view, we have got to keep faith with the 22,000 soldiers who have been wounded in Iraq, the tens and tens of thousands more who are going to be coming home with severe post-traumatic stress disorders and other problems.

I should tell you, Mr. Chairman, that my office is now working on a comprehensive piece of legislation which will include many of

the concerns that the veterans organizations have. We are going to bring that forward, and we look forward to support of Members of this Committee. The time is now to get our priorities right, and included in that is the need to take care of our veterans.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

Senator Sherrod Brown?

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you very much, Mr. Chairman.

Secretary Nicholson, thank you, and thank you for your quick responsiveness to many of us on this Committee. I appreciate that and your commitment to the Nation's veterans. I especially echo Senator Murray and her thanks of helping particularly with CBOCs in Parma, Ohio, and other outpatient clinics and your work on the consolidation in Cleveland and what that means especially for psychiatric care and especially for homeless veterans. Thank you for that.

One hundred and eight years ago, in a tailor shop in the then small town of Columbus, Ohio, the 13 veterans who recently returned from the Spanish-American War met and talked about sharing their memories, talked about their fallen comrades, talked about issues facing returning veterans coming home, talked about pensions and the fact there were no pensions, no real health care for these veterans. In that small tailor shop, out of that meeting of those 13 veterans came the VFW.

The VFW and so many other veterans organizations, from the Vietnam Vets to the American Legion to the Disabled American Vets and so many organizations, are a big reason that we are here today and a big reason that this Nation has done not always adequate, but a decent job over the years of taking care of our veterans.

As this body so often does not go much beyond being a responsive body, whether it is environmental law, whether it is the creation of Medicare and Social Security, whether it is civil rights, or whether it is veterans issues, clearly these outside organizations, like the VFW and the American Legion and others, have played such a role in getting this body to do the right thing. And I thank all the veterans organizations that have played such a major role in that, especially, as Senator Craig said, now that the VA really is the best—probably the best health care system in this country.

But I also concur with Senator Murray in that we simply—the VA and the President's budget are sorely lacking in what we really ought to be doing. We know of the problems. We have heard them stated over and over. A couple of things I wanted to address, not to go over all the issues that my colleagues—Senator Sanders and others—talked so well about.

The VA medical care funding still lags behind clearly what is needed to meet the growing number of veterans. The Administration proposal is a scant 0.14 percent, one-seventh of 1 percent, more than last year's when adjusted for inflation and increased patient utilization costs. As Senator Sanders said, we all share outrage in the VA charging Priority 7 and 8 veterans additional health

fees. It is seeking authority, as was discussed, to redirect $310 million in revenues that would be generated from these fees to the Department of the Treasury. Instead of reinvesting those dollars into a VA to help Secretary Nicholson and the Under Secretaries and the Assistant Secretaries representing the VA today, instead of helping them take care of using those funds for less affluent, if you will, by Senator Sanders' definition, to take care of them, it is money that goes back into the Treasury that pays, again, for the tax cuts that Senator Sanders mentioned.

Third, veterans should not have the lengthy waits for health care and should not be excluded from enrolling for care. The VA health care system needs to be fully funded and on time to provide for all veterans seeking care.

Lastly, there was an article in the *Miami Herald* on Sunday, I believe, that had a couple of interesting facts and charts that tell me we have a long way to go, especially on outpatient mental health care or mental health care generally in the VA. There is a chart that shows there are—based from 1995 and a decade later—I will give these to the Secretary and will ask about them. I, like Senator Rockefeller, have to leave for other committees, but will come back.

Ten years ago, there were 565,000 patients treated in the VA mental health system. Today, there are 923,000. That is no surprise, especially with this war. But, equally importantly, in 1995, outpatient mental health visits per veteran, 15.1, the average veteran receiving outpatient mental health treatment was—they paid 15.1 visits. Ten years later, in 2006, it was 11 visits per patient. I do not understand that. I think probably the VA is doing some things to discourage people, the fees, the copays, that kind of thing, to discourage people from coming.

Even more significant, perhaps, is that per patient veteran costs have come down even before correcting for inflation. In 1995, the VA was spending $3,500 per patient for mental health care. In 2004—they do not have 2005 or 2006 numbers in this chart—it was $2,500. So we are spending $1,000 less even before correcting for inflation, $1,000 less. And to compound that, some veterans get more visits, obviously, than others, but that is in part based on which clinics they are assigned to or they live near. Average number of visits per veteran with PTSD ranged from 22 in the Hudson Valley Medical Center to a low of 3.1 in Fargo, North Dakota. That is not a function of—I cannot believe that is a function of the illness of the veteran on average. It is more a function of something that the VA is doing differently or not doing right.

So all of those concerns, Mr. Chairman, we need to look at. I think that mental health coverage and care for the VA is improving, but not nearly fast enough. I am not convinced we are prepared for the next 50 years of mental health problems so many of our veterans face from this awful war. And I think that we need assurances and we need real demonstrations from the VA that they are both aware of that and are taking steps to deal with it.

I thank the Chairman.

Chairman AKAKA. Thank you very much, Senator Brown.

We will hear now from Senator Jon Tester.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I also want to thank the Secretary for being here. I very much look forward to what is said in this Committee meeting. I will make my remarks very short.

First of all, I want to tell you that everywhere I go, I am told that in the veterans' facilities you have some of the best doctors, nurses, and staff that are available. They are doing an incredible job.

On the other hand, I will also tell you that they are being burnt out. They are understaffed. And that bothers me, especially when you have quality people. So that is an issue.

We have been talking to the grassroots folks for nearly 2 years. I mean, literally that has been what I have done since May of 2005. And I can tell you that not all the people I have talked to have complaints, but there are enough of them that have complaints that make me think that there is a problem.

My barber, for example, who is a Korean War vet, is very happy with the service he gets. He has gotten through the door.

On the other side of the coin, over the last year and a half to 2 years, I cannot tell you the number of episodes that I have heard—I have not brought it up, although we did have some hearings here a couple of weeks ago with veterans about issues of access and accessibility and the folks that are trying to get through the door that cannot, that are being delayed. Several folks told me that they think the delays are intentional. They think it is because of lack of resources, money, and they think that the VA is trying to outlive them.

Now, I do not know if that is correct or not, but the truth is, if it is correct, we should be ashamed. Because as Senator Sanders said, I think that this is a cost of war that we cannot overlook, if you take a look at how this country was founded and why it was founded and what we stand for. And I think we are on the same page on that.

The health care benefits for veterans, from my perspective, is not a reward. It is a matter of fulfilling a promise that we have given our veterans. And I will tell you that. If I did not think this was an issue, if I did not think there was just a whole bunch of folks out there that have served this country so very well on the battlefield and in peacetime that deserve the benefits, I would not feel so strongly about the fact that this budget needs to be scrutinized, and it needs to be scrutinized very strongly. And, quite frankly, I do not think it is adequate.

If you take a look at the 0.14 percent increase and then assume the number of veterans—and I am sure you have got spread sheets that extrapolate this out—from the Iraqi and Afghanistan war, I think we may be put into a position where folks cannot get through the door and they cannot get the access, because I agree with Senator Murray, once they get through the door, they are getting good

health care. But the matter of fact is, I do not think that all the ones that need to get through the door are.

So I look forward to your presentation, folks. I appreciate your being here, and I appreciate being a part of this Committee.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Jim Webb?

STATEMENT OF HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA

Senator WEBB. Thank you, Mr. Chairman, and I also will attempt to be brief. We run the risk of having had the hearing before we have heard the testimony of the people here.

I want to take notice and ask the Secretary and the veterans group members to take notice of the attendance here this morning. I think it is a clear indicator of the emphasis that we on this side of the table put on veterans' issues. And I, like a number of the new Members on the Committee, actively sought to be on this Committee. We care deeply about veterans' issues.

Next month marks the 30th anniversary of when I started working formally on veterans' issues as a full committee counsel on the House side. And I have tremendous regard for the people who have dedicated their careers to working in the veterans area. I think they are among the most selfless people in Government. You find so many people who are doing this absolutely for the right reasons and dedicating their professional lives to it. And, also, to many people in the veterans groups themselves who have made themselves professionals on issues that go directly to veterans' health care.

I entered the room when the Ranking Republican was making a comparison, basically defending the current budget process, talking about why could people be attacking a 10 percent increase when they were defending a 2 percent increase during the Clinton years. And I think as my colleague Senator Sanders pointed out, there are clear reasons for that. The first, is obviously, we have entered a wartime period. There are different needs. There is a different pool of veterans coming in. And at the same time, there has been a breakdown of medical care in this country nationwide. In the last 6 years, medical costs in this country have gone up 73 percent, and 36 percent of that has been right out of people's pockets. So there has been a natural migration into the VA system.

I was a little puzzled, quite frankly, hearing this comment about how 45 percent of the veterans who are coming to the VA are Medicare eligible and have come over basically because of this prescription drug program and that that might be mitigated by Medicare D, and perhaps it will. Medicare D is in its own period of transition. But to say that those people coming into the system are doing so to the exclusion of people who do not have medical insurance basically begs the question. If both of these classes of people are eligible, why shouldn't we be treating both of them? Somewhere along the line the Government is going to pay, whether it is Medicare, TRICARE, or the VA. And the VA system, I am proud to say, as someone who has worked on and off in it for 30 years, is a wonderfully fine system. And those who have eligibility ought to be using it.

I would like to say to you, Mr. Secretary, you are aware that I have strong feelings about the need for those people who have been serving since 9/11 to get a GI bill that is worthy of their service. That is something I look forward to discussing over the coming months. There are a number of other issues that I have some concerns about, but I would be very anxious to get into the testimony, Mr. Chairman, and to hear the witnesses.

Thank you very much.

Chairman AKAKA. Thank you very much for your statement, Senator Webb.

All right. We will go into our questions now. Mr. Secretary, before we get to our questions, I want to invite you to make your statement or other statements that you have before the Committee. Again, we welcome you to the Committee.

STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL KUSSMAN, M.D., ACTING UNDER SECRETARY FOR HEALTH; DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS; WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS; AND ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT

Secretary NICHOLSON. Thank you, Mr. Chairman, Members of the Committee. Good morning. I do have a written statement I would like to submit for the record.

Chairman AKAKA. It will be included in the record.

Secretary NICHOLSON. Thank you, Mr. Chairman. I would also like to introduce my colleagues that are with me here at the table. I will start at my far left, your right: Under Secretary for Memorial Affairs, Bill Tuerk. Next to him is the Under Secretary for Benefits, Admiral Dan Cooper. To my immediate left is the Acting Under Secretary for Health, Dr. Michael Kussman. On the far right is the Assistant Secretary for Information Technology and the Chief Information Officer, Bob Howard. And on my immediate right is the Assistant Secretary for Management, and, in effect, the Chief Financial Officer of the VA, Bob Henke.

Let me preface my remarks by saying that I look forward to working with the 110th Congress, and particularly our Veterans' Committee, in a bipartisan, bicameral way of support for our Nation's veterans. I have heard said and I have said that I think taking care of our veterans is, in essence, not a partisan endeavor. It is a patriotic endeavor. And I want to offer my congratulations to the Committee's newest Members: Senators Sanders, Brown, Webb, and Tester.

I am here today to discuss the President's 2008 budget proposal for the Department of Veterans Affairs. The President is requesting a landmark budget. He is requesting nearly $87 billion to fund our Nation's commitment to America's veterans. This budget will allow us to expand the three core missions of the VA, those being: to provide world-class health care; to provide broad, fair, and timely benefits; and, third, to provide dignified burials in shrine-like settings for our Nation's veterans.

This budget will also allow us to continue our progress toward becoming a national leader in information technology and data

management. I believe that with the right resources in the hands of the right people, anything and everything is possible when it comes to caring for America's veterans.

At the VA, we already have the right dedicated people. With the President's proposed budget, we have the right resources, too. The $87 billion requested for the VA represents a 77 percent increase in veteran spending since this President took office on January 20, 2001. Medical care spending is up over 83 percent.

Mr. Chairman, I will outline the major portions of our proposed budget.

First, Veterans Health Administration. Our total medical care request is $36.6 billion in authority for our health care. VA health care is the best anywhere, and that is not just a boast of a proud Secretary—I am grateful for the complimentary remarks that have been made here by Members of the Committee. I would add that medical journals, the national media, and institutions as respected as the Harvard Medical School just recently agreed that the VA leads the Nation in health care delivery, safety, and technology.

During 2008, we expect to treat about 5.8 million patients. This total is more than 134,000 above the 2007 estimate. Patients in Priorities 1 through 6—that is, veterans with service-connected conditions, lower incomes, special health care needs, and who have had service in Iraq and/or Afghanistan—will comprise 68 percent of the total patient population in 2008. They will account for 85 percent of our health care costs. The number of patients in Priorities 1 to 6 will grow by 3.3 percent from 2007 to 2008.

In 2008, we expect to treat approximately 263,000 veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom. This is an increase of 54,000, or 26 percent, above the number of veterans from these two campaigns that we anticipate will come to us for health care during this fiscal year, and an increase of 108,000, or 70 percent, more than the number that we actually treated in 2006.

Access to this health care—With the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to health care. Ninety-six percent of primary care appointments and 95 percent of specialty care appointments are scheduled within 30 days of the desired date by the relevant veteran. We will minimize the number of new enrollees waiting for their first appointment to be scheduled. In the last 8 months, we reduced this number by 94 percent, and we will continue to place strong emphasis on this effort.

Mental health services—The President's request includes nearly $3 billion to continue our effort to improve access to mental health services across the country. Mr. Chairman, Members of the Committee, the VA is a respected leader in mental health and PTSD research and care. About 80 percent of the funds for mental health go to treat seriously mentally ill veterans, including those suffering from post-traumatic stress disorder.

Medical research—The President's 2008 budget includes $411 million to support the VA's unparalleled medical and prosthetic research program. This amount will fund nearly 2,100 high-priority research projects to expand knowledge in areas most critical to veterans' particular health care needs, most notably: research in the

areas of mental illness, $49 million; aging, $42 million; health services delivery improvement, $36 million; cancer research, $35 million; and heart disease research, $31 million. Nearly 60 percent of our research budget is devoted to OIF/OEF health care issues.

Polytrauma care—I have traveled to three of our polytrauma centers, Mr. Chairman, and there is no doubt that these centers of compassion and competent care are where miracles are performed every day. In response to the need for such specialized medical services, the VA has expanded its four traumatic brain injury centers, which are in Minneapolis, Palo Alto, Richmond, and Tampa, to a constellation of polytrauma centers encompassing 17 additional polytrauma centers to make them more accessible geographically to provide these additional specialties to treat patients with multiple complex injuries.

Seamless transition—One of the most important features of the President's 2008 budget request is to ensure that servicemembers' transition from active duty military status or mobilized Guard and Reserve to civilian life continues to be as smooth and seamless as possible. We will not rest until seriously injured or ill servicemen or women returning from combat in Iraq or Afghanistan receive the treatment that they need in a timely way.

Veterans Benefits Administration—Let me speak of veterans benefits. The VA's primary focus within the Administration of benefits remains unchanged—delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years. The volume of claims applications has grown substantially during the last few years and is now the highest that it has been in 15 years. We received more than 806,000 individual claims in 2006. That does not account for the number of issues per claimant. And we expect this high volume of claims to continue as we are expecting in the neighborhood of 800,000 claims a year in both 2007 and 2008. However, through a combination of management and productivity improvements and our 2008 request to add approximately 450 staff, which is in this budget, we will improve our performance while maintaining high quality.

We expect to improve the timeliness of processing claims to 145 days in 2008. We will make better use of new technologies and have more trained people to process and evaluate claims. With this budget, we project that we can reduce our claims processing time by 18 percent while maintaining quality.

The National Cemetery Administration—We expect to perform nearly 105,000 interments in 2008. We are 8.4 percent higher than the number of interments we performed in 2006. This is primarily the result of the aging of the World War II and Korean War veterans population and the opening of new cemeteries.

The President's 2008 budget request includes $167 million in operations and maintenance funding to activate six new national cemeteries and to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment.

Capital programs, which is construction and grants to States—The VA's 2008 request before you includes $1.1 billion in new budget authority for our capital programs. Our request includes

$727 million for major construction projects, $233 million for minor construction, $85 million in grants for State extended care facilities, and $32 million in grants to build State veterans cemeteries. The 2008 request for construction funding for our health care programs is $750 million. These resources will be devoted to a continuation of the Capital Asset Realignment for Enhanced Services, known as CARES, program.

Over the last 5 years, $3.7 billion in total funding has been provided for CARES. Within our request for major construction are resources to continue six medical facility projects already underway. Those are in Pittsburgh; Denver; Las Vegas; Orlando; Lee County, Florida; and Syracuse. Funds are already included for six new national cemeteries in Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Southeastern Pennsylvania; and Sarasota, Florida.

Information technology—VA's 2008 budget request for information technology is $1.8 billion, which includes the first phase of our reorganization of IT functions in the Department and which will establish a new IT management system in the VA. The major transformation of IT will bring our program in line with the best practices in the IT industry. Greater centralization will play a significant role in ensuring that we fulfill my promise to make the VA the gold standard for data security within the Federal Government. Toward that end, our 2008 budget IT request includes almost $70 million for enhanced cyber security.

Mr. Chairman, I know the Committee shares with me the concern about VA's ability to secure all our veterans' personal information. There have been security incidents that are simply unacceptable, and I have made it a priority to assure our veterans that we are addressing their concerns. It is not that these incidents will never occur, but when they do, the VA now has a process to properly and promptly respond to them.

We are encouraging all our employees to report, including self-reporting, thefts or other losses of equipment, whether in the workplace, at home, or on travel, so we can strengthen our information security procedures through lessons learned, review personal accountability, and, when appropriate, take disciplinary actions, including terminations.

Electronic health records—The most critical IT project for our medical care program is the continued operation and improvement of the Department's fabled electronic medical records. I have made it a point for the past year to praise our electronic health records for their ability to survive Hurricanes Rita and Katrina. Electronic health records are a Presidential priority, and VA's electronic health records system has been recognized nationally for increasing productivity, quality, and patient safety.

Within this overall initiative, we are requesting $131.9 million for ongoing development and implementation of Health*e*Vet-VistA. This is the program to modernize our existing electronic health records. It will make use of standards that will enhance the sharing of data within the VA as well as with other Federal agencies and public and private sector organizations.

Mr. Chairman, in closing, I want to take this opportunity to inform you of my plan to create a special advisory committee on OIF/

OEF veterans and their families and to mention a new initiative to assist returning veterans to connect with their State and territorial veterans departments, including the District of Columbia.

First, the OIF/OEF panel. Its membership will include veterans, spouses, survivors, and parents of combat veterans, and it will report directly to me. Under its charter, the committee will focus on ensuring that all men and women with active military service in Iraq and Afghanistan are transitioned to the VA in a seamless, informed, hassle-free manner. The committee will pay particular attention to severely disabled veterans and their families.

Second, in order to help severely injured servicemembers receive benefits from their States and territories when they move from military hospitals to VA medical facilities in their communities, I announced yesterday, with the 50 State VA Directors who were in town for a meeting, an expansion of a collaborative outreach program with the States and territories and the District of Columbia. It is called the States Benefits Seamless Transition Program. We just completed a very successful 4-month pilot with the State of Florida, and I have expanded the program to all States and territories.

This initiative is a promising extension of the VA's own transition assistance for those leaving the military service, and it is an opportunity to partner with the States to make long-term support possible for our most deserving veterans throughout the country. There are several States, for example, that totally waive ad valorem taxes for residential real estate for those seriously injured veterans.

Mr. Chairman, over the next few weeks and months, as I travel across the country, I also will be meeting with the commanders of the several combatant commands to talk to them about how the VA and the DOD can better work together to care for our soldiers, sailors, airmen, marines, and coastguardsmen who are returning from duty overseas. This Friday, I will meet with Admiral Stavridis, the Commander of the Southern Command, to brief him on the VA's programs for OIF/OEF troops. In the coming weeks, I will be meeting with the senior enlisted advisors and the Reserve chiefs. I also will be extending an invitation to each service Secretary and service Chief to meet with me so that we can keep our lines of communication open in working better for the benefit of all of our transitioning servicemen and women.

Mr. Chairman, this concludes my remarks. Thank you.

[The prepared statement of Secretary Nicholson follows:]

PREPARED STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good morning. I am pleased to be here today to present the President's 2008 budget proposal for the Department of Veterans Affairs (VA). The request totals $86.75 billion—$44.98 billion for entitlement programs and $41.77 billion for discretionary programs. The total request is $37.80 billion, or 77 percent, above the funding level in effect when the President took office.

The President's requested funding level will allow VA to continue to improve the delivery of benefits and services to veterans and their families in three primary areas that are critical to the achievement of our mission:

• To provide timely, high-quality health care to a growing number of patients who count on VA the most—veterans returning from service in Operation Iraqi Freedom

and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;

• To improve the delivery of benefits through the timeliness and accuracy of claims processing; and

• To increase veterans' access to a burial option in a national or state veterans' cemetery.

ENSURING A SEAMLESS TRANSITION FROM ACTIVE MILITARY SERVICE TO CIVILIAN LIFE

The President's 2008 budget request provides the resources necessary to ensure that servicemembers' transition from active duty military status to civilian life continues to be as smooth and seamless as possible. We will continue to ensure that every seriously injured or ill serviceman or woman returning from combat in Operation Iraqi Freedom and Operation Enduring Freedom receives the treatment they need in a timely way.

Last week, I announced plans to create a special Advisory Committee on Operation Iraqi Freedom/Operation Enduring Freedom Veterans and Families. The panel, with membership including veterans, spouses, and parents of the latest generation of combat veterans, will report directly to me. Under its charter, the Committee will focus on the concerns of all men and women with active military service in Operation Iraqi Freedom or Operation Enduring Freedom, but will pay particular attention to severely disabled veterans and their families.

We will expand our "Coming Home to Work" initiative to help disabled servicemembers more easily make the transition from military service to civilian life. This is a comprehensive intergovernmental and public-private alliance that will provide separating servicemembers from Operation Iraqi Freedom and Operation Enduring Freedom with employment opportunities when they return home from their military service. This project focuses on making sure servicemembers have access to existing resources through local and regional job markets, regardless of where they separate from their military service, where they return, or the career or education they pursue.

VA launched an ambitious outreach initiative to ensure separating combat veterans know about the benefits and services available to them. During 2006, VA conducted over 8,500 briefings attended by more than 393,000 separating servicemembers and returning reservists and National Guard members. The number of attendees was 20 percent higher in 2006 than it was in 2005 attesting to our improved outreach effort.

Additional pamphlet mailings following separation and briefings conducted at town hall meetings are sources of important information for returning National Guard members and reservists. VA has made a special effort to work with National Guard and Reserve units to reach transitioning servicemembers at demobilization sites and has trained recently discharged veterans to serve as National Guard Bureau liaisons in every state to assist their fellow combat veterans.

Each VA medical center and regional office has a designated point of contact to coordinate activities locally and to ensure the health care and benefits needs of returning servicemembers and veterans are fully met. VA has distributed specific guidance to field staff to make sure the roles and functions of the points of contact and case managers are fully understood and that proper coordination of benefits and services occurs at the local level.

For combat veterans returning from Iraq and Afghanistan, their contact with VA often begins with priority scheduling for health care, and for the most seriously wounded, VA counselors visit their bedside in military wards before separation to assist them with their disability claims and ensure timely compensation payments when they leave active duty.

In an effort to assist wounded military members and their families, VA has placed workers at key military hospitals where severely injured servicemembers from Iraq and Afghanistan are frequently sent for care. These include benefit counselors who help servicemembers obtain VA services as well as social workers who facilitate health care coordination and discharge planning as servicemembers transition from military to VA health care. Under this program, VA staff provide assistance at 10 military treatment facilities around the country, including Walter Reed Army Medical Center, the National Naval Medical Center Bethesda, the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg.

To further meet the need for specialized medical care for patients with service in Operation Iraqi Freedom and Operation Enduring Freedom, VA has expanded its four polytrauma centers in Minneapolis, Palo Alto, Richmond, and Tampa to encompass additional specialties to treat patients for multiple complex injuries. Our efforts

are being expanded to 21 polytrauma network sites and clinic support teams around the country providing state-of-the-art treatment closer to injured veterans' homes. We have made training mandatory for all physicians and other key health care personnel on the most current approaches and treatment protocols for effective care of patients afflicted with brain injuries. Furthermore, we established a polytrauma call center in February 2006 to assist the families of our most seriously injured combat veterans and servicemembers. This call center operates 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members.

In addition, VA has significantly expanded its counseling and other medical care services for recently discharged veterans suffering from mental health disorders, including post-traumatic stress disorder. We have launched new programs, including dozens of new mental health teams based in VA medical facilities focused on early identification and management of stress-related disorders, as well as the recruitment of about 100 combat veterans as counselors to provide briefings to transitioning servicemembers regarding military-related readjustment needs.

MEDICAL CARE

We are requesting $36.6 billion for medical care in 2008, a total of more than 83 percent higher than the funding available at the beginning of the Bush Administration. Our total medical care request is comprised of funding for medical services ($27.2 billion), medical administration ($3.4 billion), medical facilities ($3.6 billion), and resources from medical care collections ($2.4 billion).

Legislative Proposals

The President's 2008 budget request identifies three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a small share of the cost of their health care.

The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	Annual Enrollment
Fee Under $50,000	None
$50,000—$74,999	$250
$75,000—$99,999	$500
$100,000 and above	$750

The second legislative proposal would increase the pharmacy copayment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the last provision would eliminate the practice of offsetting or reducing VA first-party copayment debts with collection recoveries from third-party health plans.

While our budget requests in recent years have included legislative proposals similar to these, the provisions identified in the President's 2008 budget are markedly different in that they have no impact on the resources we are requesting for VA medical care. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, high-quality medical services that set the national standard of excellence in the health care industry. Unlike previous budgets, these legislative proposals do not reduce our discretionary medical care appropriations. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in mandatory receipts to the Treasury from 2008 through 2012.

Workload

During 2008, we expect to treat about 5,819,000 patients. This total is more than 134,000 (or 2.4 percent) above the 2007 estimate. Patients in Priorities 1–6—veterans with service-connected conditions, lower incomes, special health care needs, and service in Iraq or Afghanistan—will comprise 68 percent of the total patient population in 2008, but they will account for 85 percent of our health care costs. The number of patients in Priorities 1–6 will grow by 3.3 percent from 2007 to 2008.

We expect to treat about 263,000 veterans in 2008 who served in Operation Iraqi Freedom and Operation Enduring Freedom. This is an increase of 54,000 (or 26 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for health care in 2007, and 108,000 (or 70 percent) more than the number we treated in 2006.

Funding Drivers

Our 2008 request for $36.6 billion in support of our medical care program was largely determined by three key cost drivers in the actuarial model we use to project veteran enrollment in VA's health care system as well as the utilization of health care services of those enrolled:

- Inflation;
- Trends in the overall health care industry; and
- Trends in VA health care.

The impact of the composite rate of inflation of 4.45 percent within the actuarial model will increase our resource requirements for acute inpatient and outpatient care by nearly $2.1 billion. This includes the effect of additional funds ($690 million) needed to meet higher payroll costs as well as the influence of growing costs ($1.4 billion) for supplies, as measured in part by the Medical Consumer Price Index. However, inflationary trends have slowed during the last year.

There are several trends in the U.S. health care industry that continue to increase the cost of providing medical services. These trends expand VA's cost of doing business regardless of any changes in enrollment, number of patients treated, or program initiatives. The two most significant trends are the rising utilization and intensity of health care services. In general, patients are using medical care services more frequently and the intensity of the services they receive continues to grow. For example, sophisticated diagnostic tests, such as magnetic resonance imaging (MRI), are now more frequently used either in place of, or in addition to, less costly diagnostic tools such as x-rays. As another illustration, advances in cancer screening technologies have led to earlier diagnosis and prolonged treatment which may include increased use of costly pharmaceuticals to combat this disease. These types of medical services have resulted in improved patient outcomes and higher quality health care. However, they have also increased the cost of providing care.

The cost of providing timely, high-quality health care to our Nation's veterans is also growing as a result of several factors that are unique to VA's health care system. We expect to see changes in the demographic characteristics of our patient population. Our patients as a group will be older, will seek care for more complex medical conditions, and will be more heavily concentrated in the higher cost priority groups. Furthermore, veterans are submitting disability compensation claims for an increasing number of medical conditions, which are also increasing in complexity. This results in the need for disability compensation medical examinations, the majority of which are conducted by our Veterans Health Administration, that are more complex, costly, and time consuming. These projected changes in the case mix of our patient population and the growing complexity of our disability claims process will result in greater resource needs.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality health care. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class health care to veterans. For example, our record of success in health care delivery is substantiated by the results of the 2006 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School, the ACSI survey found that customer satisfaction with VA's health care system increased last year and was higher than the private sector for the seventh consecutive year. The data revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, or 10 points higher than the rating for inpatient care provided by the private-sector health care industry. VA's rating of 82 for outpatient care was 8 points better than the private sector.

Citing VA's leadership role in transforming health care in America, Harvard University recognized the Department's computerized patient records system by awarding VA the prestigious "Innovations in American Government Award" in 2006. Our electronic health records have been an important element in making VA health care the benchmark for 294 measures of disease prevention and treatment in the U.S. The value of this system was clearly demonstrated when every patient medical record from the areas devastated by Hurricane Katrina was made available to all VA health care providers throughout the Nation within 100 hours of the time the storm made landfall. Veterans were able to quickly resume their treatments, refill their prescriptions, and get the care they needed because of the electronic health records system—a real, functioning health information exchange that has been a proven success resulting in improved quality of care. It can serve as a model for the

health care industry as the Nation moves forward with the public/private effort to develop a National Health Information Network.

The Department also received an award from the American Council for Technology for our collaboration with the Department of Defense on the Bidirectional Health Information Exchange program. This innovation permits the secure, real-time exchange of medical record data between the two departments, thereby avoiding duplicate testing and surgical procedures. It is an important step forward in making the transition from active duty to civilian life as smooth and seamless as possible.

In its July 17, 2006, edition, *Business Week* featured an article about VA health care titled "The Best Medical Care in the U.S." This article outlines many of the Department's accomplishments that have helped us achieve our position as the leading provider of health care in the country, such as higher quality of care than the private sector, our nearly perfect rate of prescription accuracy, and the most advanced computerized medical records system in the Nation. Similar high praise for VA's health care system was documented in the September 4, 2006, edition of *Time Magazine* in an article titled "How VA Hospitals Became the Best." In addition, a study conducted by Harvard Medical School concluded that Federal hospitals, including those managed by VA, provide the best care available for some of the most common life-threatening illnesses such as congestive heart failure, heart attack, and pneumonia. Their research results were published in the December 11, 2006, edition of the *Annals of Internal Medicine*.

These external acknowledgments of the superior quality of VA health care reinforce the Department's own findings. We use two primary measures of health care quality—clinical practice guidelines index and prevention index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 85 percent in 2008, or a 1 percentage point rise over the level we expect to achieve this year. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index will be maintained at our existing high level of performance of 88 percent.

Access to Care

With the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to health care—96 percent of primary care appointments will be scheduled within 30 days of patients' desired date, and 95 percent of specialty care appointments will be scheduled within 30 days of patients' desired date. We will minimize the number of new enrollees waiting for their first appointment to be scheduled. We reduced this number by 94 percent from May 2006 to January 2007, to a little more than 1,400, and we will continue to place strong emphasis on lowering, and then holding, the waiting list to as low a level as possible.

An important component of our overall strategy to improve access and timeliness of service is the implementation on a national scale of Advanced Clinic Access, an initiative that promotes the efficient flow of patients by predicting and anticipating patient needs at the time of their appointment. This involves assuring that specific medical equipment is available, arranging for tests that should be completed either prior to, or at the time of, the patient's visit, and ensuring all necessary health information is available. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In addition, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

Funding for Major Health Care Programs and Initiatives

Our request includes $4.6 billion for extended care services, 90 percent of which will be devoted to institutional long-term care and 10 percent to non-institutional care. By continuing to enhance veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day health care, home-based primary care, purchased skilled home health care, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2008, we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to over 44,000.

This represents a 19.1 percent increase above the level we expect to reach in 2007 and a 50.3 percent rise over the 2006 average daily census.

The President's request includes nearly $3 billion to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders. The resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. We estimate that about 80 percent of the funding for mental health will be for the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder (PTSD). An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our ongoing outreach to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, as well as increased readjustment and PTSD services.

In 2008, we are requesting $752 million to meet the needs of the 263,000 veterans with service in Operation Iraqi Freedom and Operation Enduring Freedom whom we expect will come to VA for medical care. Veterans with service in Iraq and Afghanistan continue to account for a rising proportion of our total veteran patient population. In 2008, they will comprise 5 percent of all veterans receiving VA health care compared to the 2006 figure of 3.1 percent. Veterans deployed to combat zones are entitled to 2 years of eligibility for VA health care services following their separation from active duty even if they are not otherwise immediately eligible to enroll for our medical services.

Medical Collections

The Department expects to receive nearly $2.4 billion from medical collections in 2008, which is $154 million, or 7.0 percent, above our projected collections for 2007. As a result of increased workload and process improvements in 2008, we will collect an additional $82 million from third-party insurance payers and an extra $72 million resulting from increased pharmacy workload.

We have several initiatives underway to strengthen our collections processes:

- The Department has established a private-sector based business model pilot tailored for our revenue operations to increase collections and improve our operational performance. The pilot Consolidated Patient Account Center (CPAC) is addressing all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes. The CPAC currently serves revenue operations for medical centers and clinics in one of our Veterans Integrated Service Networks, but this program will be expanded to serve other networks.
- VA continues to work with the Centers for Medicare and Medicaid Services contractors to provide a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA health care services. We are working to include additional types of claims that will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication.
- We are conducting a phased implementation of electronic, real-time outpatient pharmacy claims processing to facilitate faster receipt of pharmacy payments from insurers.
- The Department has initiated a campaign that has resulted in an increasing number of payers now accepting electronic coordination of benefits claims. This is a major advancement toward a fully integrated, interoperable electronic claims process.

MEDICAL RESEARCH

The President's 2008 budget includes $411 million to support VA's medical and prosthetic research program. This amount will fund nearly 2,100 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($49 million), aging ($42 million), health services delivery improvement ($36 million), cancer ($35 million), and heart disease ($31 million).

VA's medical research program has a long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that are now being applied to clinical care include the discovery that vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles, development of a system that decodes brain waves and translates them into computer commands that allow quadriplegics to perform simple tasks like turning on lights and opening e-mail

using only their minds, improvements in the treatment of post-traumatic stress disorder that significantly reduce trauma nightmares and other sleep disturbances, and discovery of a drug that significantly improves mental abilities and behavior of certain schizophrenics.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2008. Through a combination of VA resources and funds from outside sources, the total research budget in 2008 will be almost $1.4 billion.

GENERAL OPERATING EXPENSES

The Department's 2008 resource request for General Operating Expenses (GOE) is $1.472 billion. This is $617 million, or 72.2 percent, above the funding level in place when the President took office. Within this total GOE funding request, $1.198 billion is for the administration of non-medical benefits by the Veterans Benefits Administration (VBA) and $274 million will be used to support General Administration activities.

Compensation and Pensions Workload and Performance Management

VA's primary focus within the administration of non-medical benefits remains unchanged—delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizable increase in workload. The volume of claims applications has grown substantially during the last few years and is now the highest it has been in the last 15 years. The number of claims we received was more than 806,000 in 2006. We expect this high volume of claims filed to continue, as we are projecting the receipt of about 800,000 claims a year in both 2007 and 2008.

The number of active duty servicemembers as well as reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 55 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed nearly doubled during the last 4 years, reaching more than 51,000 claims in 2006. Almost one in every four original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also increases workload in other parts of the Department, including the Board of Veterans' Appeals.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Also, we are now required to review the claims at more points in the adjudication process.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member, from 98 in 2006 to 101 in 2008. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices. And fourth, we will ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible and further simplify and clarify benefit regulations.

Through a combination of management/productivity improvements and an increase in resources in 2008 to support 457 additional staff above the 2007 level, we will improve our performance in the area most critical to veterans—the timeliness of processing rating-related compensation and pension claims. We expect to improve the timeliness of processing these claims to 145 days in 2008. This level of performance is 15 days better than our projected timeliness for 2007 and a 32-day improvement from the average processing time we achieved last year. In addition, we anticipate that our pending inventory of disability claims will fall to about 330,000 by the end of 2008, a reduction of more than 40,000 (or 10.9 percent) from the level we project for the end of 2007, and nearly 49,000 (or 12.9 percent) lower than the inventory at the close of 2006. At the same time we are improving timeliness, we will also increase the accuracy of our decisions on claims from 88 percent in 2006 to 90 percent in 2008.

Education and Vocational Rehabilitation and Employment Performance

With the resources we are requesting in 2008, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 15 days during the next 2 years, falling from 40 days in 2006 to 25 days in 2008. During this period, the average time it takes to process supplemental claims will improve from 20 days to just 12 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,432,000 in 2008, or 4.8 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 75 percent in 2008, a gain of 2 percentage points over the 2006 performance level. The number of program participants will rise to about 94,500 in 2008, or 5.3 percent higher than the number of participants in 2006.

Our 2008 request includes $6.3 million for a Contact Management Support Center for our education program. These funds will be used during peak enrollment periods for contract customer service representatives who will handle all education calls placed through our toll-free telephone line. We currently receive about 2.5 million phone inquiries per year. This initiative will allow us to significantly improve performance for both the blocked call rate and the abandoned call rate.

The 2008 resource request for VBA includes about $4.3 million to enhance our educational and vocational counseling provided to disabled servicemembers through the Disabled Transition Assistance Program. Funds for this initiative will ensure that briefings are conducted by experts in the field of vocational rehabilitation, including contracting for these services in localities where VA professional staff are not available. The contractors would be trained by VA staff to ensure consistent, quality information is provided. Also in support of the vocational rehabilitation and employment program, we are seeking $1.5 million as part of an ongoing project to retire over 650,000 counseling, evaluation, and rehabilitation folders stored in regional offices throughout the country. All of these folders pertain to cases that have been inactive for at least 3 years and retention of these files poses major space problems.

In addition, our 2008 request includes $2.4 million to continue a major effort to centralize finance functions throughout VBA, an initiative that will positively impact operations for all of our benefits programs. The funds to support this effort will be used to begin the consolidation and centralization of voucher audit, agent cashier, purchase card, and payroll operations currently performed by all regional offices.

NATIONAL CEMETERY ADMINISTRATION

The President's 2008 budget request includes $166.8 million in operations and maintenance funding for the National Cemetery Administration (NCA). These resources will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment. We expect to perform nearly 105,000 interments in 2008, or 8.4 percent higher than the number of interments we performed in 2006. The number of developed acres (over 7,800) that must be maintained in 2008 will be 7.3 percent greater than last year.

Our budget request includes $3.7 million to prepare for the activation of interment operations at six new national cemeteries—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; southeastern Pennsylvania; and Sarasota County, Florida. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003.

The 2008 budget has $9.1 million to address gravesite renovations as well as headstone and marker realignment. These improvements in the appearance of our

national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 84.6 percent in 2008, which is 4.4 percentage points above our performance level at the close of 2006. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2008, or 4 percentage points higher than the level of performance we reached last year.

CAPITAL PROGRAMS (CONSTRUCTION AND GRANTS TO STATES)

VA's 2008 request includes $1.078 billion in appropriated funding for our capital programs. Our request includes $727.4 million for major construction projects, $233.4 million for minor construction, $85 million in grants for the construction of state extended care facilities, and $32 million in grants for the construction of state veterans cemeteries.

The 2008 request for construction funding for our health care programs is $750 million—$570 million for major construction and $180 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program, total funding for which comes to $3.7 billion over the last 5 years. CARES will renovate and modernize VA's health care infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Within our request for major construction are resources to continue six medical facility projects already underway:

- Denver, Colorado ($61.3 million)—parking structure and energy development for this replacement hospital.
- Las Vegas, Nevada ($341.4 million)—complete construction of the hospital, nursing home, and outpatient facilities.
- Lee County, Florida ($9.9 million)—design of an outpatient clinic (land acquisition is complete).
- Orlando, Florida ($35.0 million)—land acquisition for this replacement hospital.
- Pittsburgh, Pennsylvania ($40.0 million)—continue consolidation of a 3-division to a 2-division hospital.
- Syracuse, New York ($23.8 million)—complete construction of a spinal cord injury center.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Our 2008 request for minor construction funds for medical care and research will provide the resources necessary for us to address critical needs in improving access to health care, enhancing patient privacy, strengthening patient safety, enhancing research capability, correcting seismic deficiencies, facilitating realignments, increasing capacity for dental services, and improving treatment in special emphasis programs.

We are requesting $191.8 million in construction funding to support the Department's burial program—$167.4 million for major construction and $24.4 million for minor construction. Within the funding we are requesting for major construction are resources to establish six new cemeteries mandated by the National Cemetery Expansion Act of 2003. As previously mentioned, these will be in Bakersfield ($19.5 million), Birmingham ($18.5 million), Columbia-Greenville ($19.2 million), Jacksonville ($22.4 million), Sarasota ($27.8 million), and southeastern Pennsylvania ($29.6 million). The major construction request in support of our burial program also includes $29.4 million for a gravesite development project at Fort Sam Houston National Cemetery.

INFORMATION TECHNOLOGY

VA's 2008 budget request for information technology (IT) is $1.859 billion. This budget reflects the first phase of our reorganization of IT functions in the Department which will establish a new IT management structure in VA. The total funding for IT in 2008 includes $555 million for more than 5,500 staff who have been moved to support operations and maintenance activities. Prior to 2008, the funding and staff supporting these IT activities were reflected in other accounts throughout the Department.

Later in 2007, we will implement the second phase of our IT reorganization strategy by moving funding and staff devoted to development projects and activities. As a result of the second stage of the IT reorganization, the Chief Information Officer will be responsible for all operations and maintenance as well as development activities, including oversight of, and accountability for, all IT resources within VA. This reorganization will make the most efficient use of our IT resources while improving operational effectiveness, providing standardization, and eliminating duplication.

This major transformation of IT will bring our program under more centralized control and will play a significant role in ensuring we fulfill my promise to make VA the gold standard for data security within the Federal Government. We have taken very aggressive steps during the last several months to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information, launching an initiative to expeditiously upgrade all VA computers with enhanced data security and encryption, entering into an agreement with an outside firm to provide free data breach analysis services, initiating any needed background investigations of employees to ensure consistency with their level of authority and responsibilities in the Department, and beginning a campaign at all of our health care facilities to replace old veteran identification cards with new cards that reduce veterans' vulnerability to identify theft. These steps are part of our broader commitment to improve our IT and cyber security policies and procedures.

Within our total IT request of $1.859 billion, $1.304 billion (70 percent) will be for non-payroll costs and $555 million (30 percent) will be for payroll costs. Of the non-payroll funding, $461 million will support projects for our medical care and medical research programs, $66 million will be devoted to projects for our benefits programs, and $446 million will be needed for IT infrastructure projects. The remaining $331 million of our non-payroll IT resources in 2008 will fund centrally managed projects, such as VA's cyber security program, as well as management projects that support department-wide initiatives and operations like the replacement of our aging financial management system and the development and implementation of a new human resources management system.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting $131.9 million for ongoing development and implementation of Health*e*Vet-VistA (Veterans Health Information Systems and Technology Architecture). This initiative will incorporate new technology, new or reengineered applications, and data standardization to improve the sharing of, and access to, health information, which in turn, will improve the status of veterans' health through more informed clinical care. This system will make use of standards accepted by the Secretary of Health and Human Services that will enhance the sharing of data within VA as well as with other Federal agencies and public and private sector organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to them and to all those authorized to provide care to veterans.

Until Health*e*Vet-VistA is operational, we need to maintain the VistA legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $129.4 million in 2008 for the VistA legacy system. Funding for the legacy system will decline as we advance our development and implementation of Health*e*Vet-VistA.

In veterans benefits programs, we are requesting $31.7 million in 2008 to support our IT systems that ensure compensation and pension claims are properly processed and tracked, and that payments to veterans and eligible family members are made on a timely basis. Our 2008 request includes $3.5 million to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will, when fully deployed, receive application and enrollment information and process that information electronically, reducing the need for human intervention.

VA is requesting $446 million in 2008 for IT infrastructure projects to support our health care, benefits, and burial programs through implementation and ongoing management of a wide array of technical and administrative support systems. Our request for resources in 2008 will support investment in five infrastructure projects now centrally managed by the CIO—computing infrastructure and operations ($181.8 million); network infrastructure and operations ($31.7 million); voice infra-

structure and operations ($71.9 million); data and video infrastructure and operations ($130.8 million); and regional data centers ($30.0 million).

VA's 2008 request provides $70.1 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide controls to better secure our IT architecture in support of all of the Department's program operations. Our request also includes $35.0 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a long-standing material weakness and will effectively integrate and standardize financial and logistics data and processes across all VA offices as well as provide management with access to timely and accurate financial, logistics, budget, asset, and related information on VA-wide operations. In addition, we are asking for $34.1 million for a new state-of-the-art human resource management system that will result in an electronic employee record and the capability to produce critical management information in a fraction of the time it now takes using our antiquated paper-based system.

SUMMARY

Our 2008 budget request of $86.75 billion will provide the resources necessary for VA to:

- Strengthen our position as the Nation's leader in providing high-quality health care to a growing patient population, with an emphasis on those who count on us the most—veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
- Improve the delivery of benefits through the timeliness and accuracy of claims processing; and
- Increase veterans' access to a burial option by opening new national and state veterans' cemeteries.

I look forward to working with the Members of this Committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO HON. R. JAMES NICHOLSON, SECRETARY, DEPARMENT OF VETERANS AFFAIRS

Question 1. VA's estimates for the number of OEF/OIF veterans that will come into the system next year are relatively incremental, at around 54,000. In the past, VA has underestimated the number of new veterans seeking VA health care. We also know that some conditions, such as PTSD, can take some time to manifest themselves in these young servicemembers, and that in these current conflicts, the average servicemember will serve more tours than in the past. Can you please explain the projects that VA will see such a low number of OEF/OIF veterans next year? In our hearing, you mentioned that you use a very sophisticated model to reach your projections can you explain this model?

Response: The Department of Veterans Affairs (VA) has made every effort to account for the needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans within the actuarial model. Starting with the identification of OEF/OIF veterans from a roster provided by the Department of Defense (DOD) the actuarial model develops projections based on the actual enrollment and utilization patterns of OEF/OIF veterans since Fiscal Year (FY) 2002. These projections are based on the development of separate enrollment, morbidity, and reliance assumptions for OEF/OIF veterans based on their actual enrollment and utilization patterns. However, unknowns, such as the length of the conflict, will impact the services that VA will need to provide. Therefore, we have included additional investments for OEF/OIF in the Fiscal Year 2008 budget to ensure that VA is able to care for all of the health care needs of our returning veterans.

Question 2. VA has indicated that the size of the active duty force is the best indicator of new claims activity. DOD data shows that there were nearly 198,000 military separations in 2006. This number does not include demobilized Guard and Reserve. Trends show that 35 percent of these veterans will file a claim over the course of their lifetime. For 2006 separation only, that number is over 69,000 for just active duty forces. What is VA doing to prepare now for this current and future increase in claims activity?

Response: Special workload reduction initiatives are being undertaken to meet the demands of pending and future inventory. These initiatives include an aggressive recruitment program to add more decisionmakers; employment of rehired annu-

itants; expanded use of overtime; expansion of our claims development centers; shifting work among regional offices to maximize resources and enhance performance; improving the training for new and existing employees; and working with DOD to identify opportunities to improve information sharing and efficiency of claims processing and transition services. The 8,320 direct full time employees (FTE) requested in 2008 for the Compensation and Pension (C&P) program are essential if VA is to reduce the pending workload. With a workforce that is sufficiently large, correctly balanced, and well trained, the Veterans Benefit Administration (VBA) can successfully meet the needs of our veterans.

Question 3. How many veterans does VA estimate will leave the VA health care system due to the enrollment fees and increase in the drug copayment, and how many veterans will be deterred from seeking services at VA?

Response: VA estimates that approximately 420,000 Priority 8 veterans will choose not to pay the tiered enrollment fee and increased pharmacy copayment in Fiscal Year 2009. A majority of these veterans are non-users but approximately 111,000 veteran patients are impacted by this proposal.

Question 4. Over the past 5 years, VA has made extraordinary progress in developing new solutions to the medical needs of our aging veterans population and the growing number of younger veterans with multiple traumatic injuries. Yet, the research request for Fiscal Year 2008 relies on outside funding sources, and would amount to a cut of $2 million authorized from Fiscal Year 2007. In a similar trend, the budget requests 3,000 research employees, down by almost 200 from 2006. Please explain the motivation for these cuts, and the impact they will have on the impressive research conducted at VA?

Response: VA is committed to increasing the impact of its research program by ensuring that resources are targeted to the most pressing needs and spent on the programs that prove to be most effective at developing new solutions to the medical needs of new and aging veterans.

VA continues to maintain a workable balance among the competing needs for research; to evaluate and fund existing programs at appropriate levels and to fund new projects at a comparable rate as has happened previously. Strategies include using attrition, transitioning to shorter durations of awards, and conducting competitive reviews of research centers. VA is using performance-based criteria to decide whether to modify, terminate, or expand programs.

Using these strategies, VA research is increasing its focus on the emerging needs of new veterans, especially those returning from OEF/OIF, while maintaining a broad research portfolio that addresses the needs of aging veterans, including chronic diseases and mental health. It is important to note that, in many cases, the needs of new OEF/OIF veterans relate to those of aging veterans who served in previous conflicts. For example, research focused on the combat-related mental health needs of OEF/OIF veterans is also applicable to the mental health needs of aging veterans who served in previous deployments. Similarly, research designed to improve traumatic amputation and subsequent prosthetics care is also relevant to aging veterans with diabetes and vascular disease. Accordingly, increases in funding for OEF/OIF related research does not necessarily come at the expense of research focused on the aging veteran.

Question 5. How does VA handle OEF/OIF veterans as they enter the VA system through their 2-year automatic window of eligibility following separation from service? Are all of them automatically "enrolled" in the VA health care system? And how are they prioritized after their enrollment or entry into the system? Do they automatically become 7s and 8s?

Response: Combat veterans, including OEF/OIF veterans, who apply for enrollment within 2 years of their release from active duty are eligible for placement into Priority Group 6 (unless they are eligible for placement in a higher Priority Group based on other eligibility factors).

These combat veterans are eligible for the full medical benefits package. They are provided hospital care, medical services, nursing home care, and medications for any illness that may be related to their combat service during the 2 years after their release from active duty is provided without charge. Treatment for conditions other than those clinically determined to be related to their service are subject to copays.

At the end of their 2-year combat eligibility period, enrolled combat veterans remain enrolled and are placed into Priority Groups based upon their income and/or other applicable eligibility factors. Combat veterans who apply more than 2 years after separation from active duty are evaluated for enrollment based upon the same eligibility factors as any other veteran.

Question 6. The proposed budget would maintain the current ban on enrollment of Priority 8 veterans. How much would it cost to bring these veterans back into

the system? Please take into account the third party insurance these veterans will bring with them.

Response: Reopening Priority 8 enrollment in Fiscal Year 2008 is estimated to increase enrollment in Priority 8 by approximately 1.6 million and require an additional $1.7 billion in the budget. VA has significant concerns that this additional demand will strain VA's capacity to provide timely, quality care for all enrolled veterans and will lead to longer waits for care. VA must also consider the impact of this policy in future years. In 2017, this policy would increase Priority 8 enrollment by an estimated 2.4 million and would require an additional $4.8 billion. Over the next 10 years, resumption of Priority 8 enrollment would require an additional $33.3 billion.

Question 7. VA's budget appears not to add $360 million but only $54 million to implement mental health initiatives to close gaps in services identified in VA's Mental Health Strategic Plan. Can you please provide the Committee with a detailed breakdown of how the $306 million will be spent in Fiscal Year 2007 and how the VA proposed to spend the additional $54 million in Fiscal Year 2008?

Response: The plan for spending the $306 million allocated for the mental health initiative is included as a spreadsheet. The additional funds for the Mental Health Initiative for Fiscal Year 2008 will be fully used to support full year funding for those activities initiated in Fiscal Year 2007 and prior years.

The following table provides additional information.

FY 2007 and FY 2008 Proposed Mental Health Initiative Spend Plan	FY 2007	FY 2008	Change
Continuation of FY 2005 and FY 2006 Recurring Initiated Activities	166,296,744	166,296,744	0
Primary Care/Mental Health Integration	38,380,506	55,691,153	17,310,647
Suicide prevention coordinators (156 sites)	8,624,890	16,249,780	7,624,890
Psychosocial Rehabilitation (PSR)	15,138,061	23,587,385	8,449,324
Mental Health Intensive Case Management (MHICM): Rural, multiple teams, etc.	10,185,091	12,345,644	2,160,553
Homeless Program Initiatives	17,556,002	17,342,238	−213,764
Substance Use Disorders	4,624,702	9,096,072	4,471,370
Mental Health staff in Community Based Outpatient Clinics (CBOCs)	15,290,157	21,883,139	6,592,982
Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) inreach	3,490,567	5,102,231	1,611,664
Post Traumatic Stress Disorder (PTSD), including Dual Diagnosis and Military Sexual Trauma (MST) Resource program	4,979,157	5,115,401	136,244
Telemental Health	7,018,000	3,100,000	−3,918,000
EES training	600,000	600,000	0
Centers of Excellence	3,000,000	4,950,000	1,950,000
Gulf Coast market survey	196,659	0	−196,659
Vet Center staff enhancement	3,379,923	10,531,046	7,151,123
TBI Transitional Housing	2,500,000	5,000,000	2,500,000
Other activities including training in evidence based psychotherapy	4,849,541	3,109,167	−1,740,374
Total	306,110,000	360,000,000	53,890,000

Question 8. I remain concerned that the funding for new mental health initiatives may be inadequate. VA has been implementing the Mental Health Strategic Plan since Fiscal Year 2005. Please identify the initiatives in the plan that have not been fully implemented and the amounts of funding needed to fully implement each of the remaining initiatives.

Response: The Veterans Health Administration (VHA) mental health strategic plan (MHSP) identifies and addresses gaps in services, disseminates evidence-based programs, and works toward transformation in the culture of care. While VHA has been working toward implementation of the MHSP for approximately 2 years, we anticipate that 5 years or more will be required to achieve the enhancements and transformations required to fully meet its intended goals.

In terms of initiatives that have not been fully implemented, VA views the MHSP as a living document that must be modified or interpreted differently as the needs of eligible veterans change, and as new opportunities for providing care become available. For example, VA has learned far more about the needs of veterans from the Global War on Terrorism (GWOT) since 2003 and 2004 when the strategic plan was developed. We have also learned from research about new opportunities for treating veterans with mental illnesses.

Resources to support mental health services have come in the form of supplementing Veteran Integrated Service Network (VISN)-based activities funded

through veteran's equitable resource allocation (VERA). Enhancements funded through the mental health initiative are moving the system rapidly toward implementation of the MHSP. Extending the funding for the initiative with $306 million in Fiscal Year 2007 and $360 million in Fiscal Year 2008 will contribute to the transformation of the mental health care system and full implementation of the MHSP.

Question 9. VA's ability to provide for the security of our veterans' personal information is still questionable. I understand this budget contains over $70 million for cyber security. Please explain in detail how this money will be used. How will this budget prevent future losses of computer equipment and secure personal information of the type that is believed to be on the hard drive at the Birmingham VA Medical Center that was reported lost last month?

Response: The information technology (IT) cyber security program includes 18 initiatives, as follows:

Initiative	FY 2008
Cyber Security Management	$28.7M
Certification & Accreditation of IT Systems	7.5
Identity Safety and Risk Management	6.0
Policy Development and Maintenance	5.7
Training, Awareness and Education	5.4
FISMA Reporting	2.3
Security Inspection	1.8
Field Security Operations	$41.4M
Enterprise Encryption and Data Protection	7.0
Maintenance/Support Services	6.5
Enterprise Framework	5.5
Antivirus	5.4
Vulnerability Assessment and Penetration	4.0
Patch Management	3.4
Encryption	2.7
Testing	2.2
Intrusion Prevention	1.9
E-Authentication	1.9
Media Disposal	0.5
COOP	0.4
Total	$70.10M

To account for equipment and protect information, VA is:

• Requiring all VA laptops have security software updated and unauthorized sensitive information removed through the laptop "Health Check" procedure every 90 days.

• Permitting the use of Federal Information Processing Standards (FIPS) 140–2 certified encrypted universal serial buses (USB) thumb drives for VA employees who have justified the need and received approval to store information on a removable storage device as outlined in VA Directive 6601, Removable Storage Media.

• Testing a port security technology to enforce adherence to the directive that will restrict the transfer of information to removable storage media and thwart the introduction of malicious code via USB ports.

• Establishing levels of standardization and maintaining an inventory for Blackberry devices, SmartPhones and other mobile devices (such as personal digital assistants).

• Implementing Blackberry content protection on devices VA owns, i.e., if a device is lost, it is password protected and encrypted.

• Restricting use of non-government mobile devices within VA, only allowing them to be used if VA can monitor their use to verify they are following VA IT security policies.

• Deploying an encryption solution for SmartPhones and other mobile devices similar to that of the Blackberry protection.

• Securing remote access to e-mail and file shares for employees, contractors, and business partners using government furnished equipment through the remote enterprise security compliance update environment (RESCUE), which ensures equipment

is encrypted and has an active host-based firewall, updated antivirus files, and the most recent security patches mandated for installation.

• Prohibiting employees, contractors and business partners from saving information on non-government owned equipment.

• Testing technology to encrypt network traffic from VistA mail, computerized patient record system and time and attendance applications.

• Automating the distribution of software, patches and upgrades to servers and workstations via the enterprise security framework to ensure policy compliance for VA information systems, to produce compliance reports, and to mitigate risks—in concert with the VA patch management, intrusion prevention and antivirus initiatives—propagated by viruses, worms, and other malicious code.

• Distributing data eraser (a software package for overwriting sensitive information contained on hard drives) nationwide to properly sanitize and dispose of equipment.

• Conducting vulnerability assessments and penetration testing to identify and quantify risks.

• Drafting/implementing policies addressing agency responsibilities to protect laptops and other portable data storage and communication devices, such as keeping laptops in carry-on luggage, use of privacy screens when accessing agency information outside the office, etc.

Question 10. As discussed in the past, I am concerned that VA cannot always absorb court decisions, anticipated or not, without falling behind. This year, we already know of a court decision that could have a significant effect on the workload at VA. What measures are you taking now to ensure that should the Haas decision not be overturned, that veterans who are already in the queue, or those who are now filing their claims, are not burdened by unnecessary delay?

Response: The Haas decision could potentially affect many veterans who have claims based on herbicide exposure in which the only evidence of exposure is the receipt of the Vietnam Service Medal or service on a vessel off the shore of Vietnam, i.e., there is no evidence they served on land or the inland waterways of Vietnam. In order to be prepared for adjudication of claims that will be influenced by the decision rendered by the U.S. Court of Appeals for the Federal Circuit, VA released instructions in December of 2006 to all regional offices on the correct process for tracking and controlling claims with Haas issues.

The initiatives that have recently been put in place to address increased inventory will assist VA in tackling the potential increase in claims that may stem from Haas. These initiatives include an aggressive recruitment program to add more decision-makers, employment of rehired annuitants, increased use of overtime, expansion of claims development centers, shifting work among regional offices to maximize resources and enhance performance, and improved training for all employees.

Question 11. How is the Department counting injuries that come about as a result of participation in the Global War on Terror? Are combat and non-combat injuries categorized differently?

Response: The Office of Public Health and Environmental Hazards does perform a quarterly review of healthcare use by those OEF/OIF veterans who have separated from service and present to VA for care. Since September 2003, DOD Defense Manpower Data Center (DMDC) has developed an updated file of "separated" Afghan and Iraqi combat troops who have become eligible for VA health care. This roster is used to check the VA's electronic inpatient and outpatient health records, in which the standard International Classification of Disease (ICD)–9 diagnostic codes are used to classify health problems, to determine which OEF/OIF veterans have accessed VA health care. The data available for this analysis are mainly administrative information and are not based on a review of each patient record or a confirmation of each diagnosis. However, every clinical evaluation is captured in VHA's computerized patient record. Consequently, the data used in this analysis are excellent for health care planning purposes because the ICD–9 administrative data reflects the need for health care resources.

VA/DOD social work liaisons located at 10 military treatment facilities (MTFs) assist with the transfer of seriously injured servicemembers to the most appropriate VA medical facilities closest to their home to meet their medical needs. These VA/DOD social work liaisons categorize the nature of the injury (battle, non-battle or disease) as part of their documentation and referral to the receiving VA medical facility. From August 2003 to February 22, 2007, VA/DOD liaisons received the following referrals:

Military Class of Injury	Patient Count	Percent of Total
Battle Injury (BI)	1,215	20.3
Non-Battle Injury (NBI)	2,303	38.5
Disease	1,467	24.6
Unknown	990	16.6
Total Uniques	5,975	100

Data Source: MTF2VA Tracking System.

Question 12. What is the justification for moving a claim filed as a result of the Global War on Terror ahead of an initial claim filed by a Vietnam veteran?

Response: VA's initiative to provide priority processing of all OEF/OIF veterans' disability claims will allow all the brave men and women returning from the OEF/OIF theaters who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability benefits as soon as possible after separation. We believe this is an important step in assisting them with their transition to civilian life.

VBA has undertaken several improvement initiatives to reduce the pending workload and shorten the waiting time for all veterans. We are hiring more employees and devoting additional resources to claims processing. Additional overtime funds have been provided to regional offices, and we are recruiting retired claims processors to return to work as rehired annuitants. These experienced claims processors will be tasked with processing claims that have been pending the longest. Through these initiatives, claims processing for all veterans will be improved.

Question 13. How was the strategic target for average days to mark a grave at national cemeteries developed? Now that the National Cemetery Administration is performing well-above the strategic target, will the strategic target be adjusted to make the goal higher?

Response: The strategic target for the timeliness (within 60 days of interment) of marking graves in national cemeteries was originally set at 90 percent based on a review of performance data and of the business processes involved with furnishing headstones and markers at national cemeteries. In Fiscal Year 2002, the National Cemetery Administration (NCA) collected baseline data showing that 49 percent of graves in national cemeteries were marked within 60 days of interment. This level of performance was raised by reengineering business processes, such as ordering and setting headstones and markers. In Fiscal Year 2004 and 2005, NCA exceeded this initial strategic target, marking 94 percent and 95 percent of graves in national cemeteries within 60 days of interment, respectively. As a result, NCA has increased the strategic target for this measure to 92 percent.

While NCA's improved performance in this key strategic measure is due primarily to reengineered business processes, favorable weather conditions over the past few years, especially during the winter months in the Northeast and Midwest, have also positively impacted our performance. External factors beyond NCA's control, such as extreme weather conditions that impact ground conditions, may cause delays in the delivery and installation of headstones and markers. Additionally, some families may choose to delay the ordering of a headstone or marker for the grave of an individual interred in a national cemetery, which may impact our ability to mark graves within 60 days of interment. While national cemetery staff work with families and funeral homes to ensure the ordering of headstones and markers in a timely manner, we respect that some families may choose to defer ordering their headstone or marker until a later date. With these factors in mind, NCA is currently focused on sustaining our high level of performance in this area and continuing to achieve and surpass our current strategic target.

Question 14. Please explain the 310 day change in the Appeals Resolution Time Strategic Target from last year to this year.

Response: The Board of Veterans Appeals (Board or BVA) appeals resolution time (ART) is the average length of time it takes the Department to process an appeal from the date a claimant files a Notice of Disagreement (NOD) until a case is resolved, including resolution at a regional office or by issuance of a final, non-remand, decision by the Board. This Department-wide timeliness measure was adopted in the late 1990s as a major organizational crosscutting effort to demonstrate the Board's and VBA's commitment to veterans. We recognize that appellants are less interested in how long individual stages in the appeals process take as they are about the length of the entire process. ART provides appellants, elected officials, De-

partmental leadership, VBA and BVA management, and other interested parties a much more comprehensive and accurate answer to the question, "How long does the appeal process take?" For the reasons that will be discussed below, the strategic target for the ART for Fiscal Year 2007 was revised from the longstanding goal of 365 days to 675 days to more realistically and accurately reflect the actual length of the appeals process.

The goal established in 1998 was 365 calendar days. However, that goal has never been met (see chart below). Moreover, this goal was established before the Veterans Claims Assistance Act (VCAA) was enacted in November 2000. Prior to that time, VA evaluated claims to determine whether they were "well grounded." If they were not, VA did not assist the claimant in the development of his or her claims. The VCAA, among other things, heightened VA's duty to assist and duty to notify claimants of the type of evidence needed to substantiate their claim. This resulted in more steps to the claims process and an increase in the length of time required to develop claims. In addition, the U.S. Court of Appeals for Veterans Claims and the U.S. Court of Appeals for the Federal Circuit have issued a series of precedent decisions, which required additional action on VA's part. *See Holliday* v. *Principi*, 14 Vet. App. 280 (2001); *Quartuccio* v. *Principi*, 16 Vet. App. 183 (2002); *Charles* v. *Principi*, 16 Vet. App. 370 (2002); *Pelegrini* v. *Principi*, 18 Vet. App. 112 (2002); *Mayfield* v. *Nicholson*, 444 F.3d 1328 (Fed. Cir. 2006); *Dingess/Hartman* v. *Nicholson*, 19 Vet. App. 473 (2006); *Kent* v. *Nicholson*, 20 Vet. App. 1 (2006).

Fiscal Year	Target ART	Actual ART	Strategic Target ART
1999		745	365
2000		682	365
2001		595	365
2002		731	365
2003		633	365
2004		529	365
2005		622	365
2006		657	365
2007	685	670*	675
2008	700		675

*Thru 1/31/07.

Question 15. The Administration's request projects an increase in funding for VA health care in Fiscal Year 2008, and cuts in funding in subsequent years. This projection parallels last year's request which suggested cuts in immediate out years as well. In the face of steadily increasing patient workload, an aging veteran population, and steady inflation in the cost of medical care, what is the rationale for these projections?

Response: The Administration determines the details of its appropriations request 1 year at a time. Each year, Office of Management and Budget (OMB) works with the agencies to develop the detail estimates for individual programs. OMB's computer model generates placeholders for, in the case of this year's budget, Fiscal Year 2009–2012 by account that hit overall targets for defense, homeland security, international, and other non-security spending, so that OMB can calculate the deficit path. These projections do not represent the President's proposed levels for individual accounts and programs. The Fiscal Year 2009 and subsequent year's requests will be made in future cycles.

Question 16. The proposed budget shows a transfer of 5,689 Food Service FTE from the medical facilities to medical services account. How are these personnel to be distributed amongst the medical services activities? What is the justification for this change?

Response: This is a technical correction. Under the medical care three-appropriation structure, which began in 2004, food service operations were designated under the medical facilities appropriation. The costs incurred for hospital food service workers, provisions, and related supplies are for the direct care of patients. Food service costs are directly related to inpatient workload and, therefore, should be captured under the medical services appropriation which is responsible for direct inpatient care. VA requests that beginning in 2008, food service operations be moved to the medical services appropriation.

Question 17. The proposed budget includes $1.3 billion allocated for the IT nonpay account. How is this budget line allocated? What portion of this line will be

spent on outside contracts? How many individual contracts do you expect to make use of, and with how many individual contractors? How much of this line represents contractor payroll?

Response: The proposed budget of $1.3 billion is allocated, as follows (dollars in thousands):

IT Activities	2008 estimate
VA IT Infrastructure	$446,139
Veterans Health Care	461,468
Veterans Benefits Delivery	65,648
Office of Information and Technology	191,034
Office of Management	82,572
Human Resources Development	34,140
Other Staff Offices	22,840
Impact of Continuing Resolution P.L. 109–383.	
Total	$1,303,841

With respect to the remaining contractor-specific questions, the volume and detail of data necessary to provide an adequate response will require an extensive informationgathering effort. As a result, VA needs significant time to collect this data. However, we expect to be able to complete the response by June 30, 2007.

Question 18. FISMA compliance accounts for $249 million of the IT budget. Please explain in detail how these funds will be expended to improve VA's level of FISMA compliance.

Response: The information technology component of the budget request includes $231.9 million for compliance with the information security requirements of Federal Information Security Management Act (FISMA) compliance.

The Department-level budget of $70.1 million for cyber security provides an overall framework for development and implementation of the VA information security program as required by FISMA. This includes a:

• Cyber security management component that provides the Department-wide focal point for leadership in information security policies, procedures, and practices; and

• Regional field operations component that provides oversight for a segment of facility information security officers who are geographically dispersed throughout VA as well as develops and maintains certain enterprise-wide security controls and measures.

The IT system-level budget, which is $161.8 million spread across the IT portfolio for implementation, comprises security initiatives accomplished at the system or facility level to support FISMA compliance (to include implementation of security controls required by the National Institute of Standards and Technology). For Fiscal Year 2008, anticipated expenditures are related to re-certification and accreditation of approximately 560 VA systems; deployment of the VA personal identify verification system to provide standardized government identification and access to IT systems for over 350,000 VA employees and contractors; integration of security into VistA application development; secure deployment of the VA regional data centers; remediation of facility security weaknesses; temporary employee background investigations; field level contingency plan testing; and system security upgrades.

Question 19. Please provide in detail VA's outreach efforts to the Guard and Reserve, including specific actions and numbers of servicemembers contacted, as well as the number of servicemembers seeking benefits and services.

Response: VHA has made extensive efforts to ensure that information is available to returning troops about VA services and their eligibility. Ultimately it is each veteran's decision regarding where they will seek health care, but VA wants that decision to be based on ample information about VA and its programs for veterans. VBA, with the activation and deployment of large numbers of Reserve/Guard members, has greatly expanded its outreach to this group of veterans as well. The following is a summary of efforts to reach out and educate veterans and their families: Transition Assistance Advisors (TAA): The Office of Seamless Transition has partnered with the National Guard Bureau to establish 54 TAA, formerly State benefits advisors. A TAA is in every State and territory. The TAAs are National Guard Bureau staff that work closely with VA medical centers and Vet Centers in outreach, education, and referral efforts.

Post Deployment Health Reassessment (PDHRA) Program: VA Medical Centers (VAMC) and Vet Centers are heavily involved in DOD PDHRA program for National Guard and Reserve members. PDHRA is an outreach, education, identification, and

referral program. Vet Center staff has participated in over 300 PDHRA screening events with National Guard and Reserve units. These screenings have resulted in over 17,125 servicemembers, as of February 2007, being referred to VA for follow-up care. In addition to providing this follow-up care, VA staff actively enrolls National Guard and Reserve members in health care.

Army Wounded Warrior (AW2): Recently VA has agreed to host 22 AW2 staff in VAMCs to work with seriously injured soldiers/veterans and their families. AW2 soldiers have 30 percent or higher disability ratings from the Army. Over 20 percent of the soldiers/veterans in this program have a post traumatic stress disorder (PTSD) disability. An AW2 staff will be located in each VISN (with two assigned in VISN 7). Sixteen of the AW2 staff are currently in place with the remaining six scheduled to be assigned during 3rd quarter Fiscal Year 2007. The VA/AW2 partnership is a major step in the outreach initiative that will help VAMC and Vet Center staff reach out to seriously injured soldiers/veterans and their families.

Memorandums of Understanding (MOU): The Office of Seamless Transition is actively working with the Army Reserve and the Marine Corps to develop MOUs to help promote outreach, education, and transition assistance.

Vet Center Enhancements: In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers have hired additional staff and opened new centers. In February 2004, 50 GWOT veterans were hired to augment the Vet Center existing staff. VA authorized a new 4-person Vet Center in Nashville, Tennessee in November 2004. An additional 50 GWOT veterans were hired in April 2005 to further enhance services to veterans returning from combat in Afghanistan and Iraq. VA established two new Vet Centers (Atlanta, Georgia and Phoenix, Arizona) in April 2006. Since the beginnings of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 165,000 OEF/OIF veterans, of which over 119,000 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites, usually in group settings.

Vet Center Expansion: In February 2007 a major expansion of the Vet Center program was announced, with 23 new Vet Centers to be located in Montgomery, AL; Fayetteville, AR; Modesto, CA; Grand Junction, CO; Orlando, Fort Myers, and Gainesville, FL; Macon, GA; Manhattan, KS; Baton Rouge, LA; Cape Cod, MA; Saginaw and Iron Mountain, MI; Berlin, NH; Las Cruces, NM; Binghamton, Middletown, Nassau County and Watertown, NY; Toledo, OH; Du Bois, PA; Killeen, TX; and Everett, WA.

Returning Veterans Outreach, Education and Clinical (RVOEC) Teams: RVOEC teams (funded and monitored through the Office of Mental Health Services) collaborate with readjustment counseling services and with State veterans affairs offices to provide information about VA services. A primary goal of the RVOEC program is to promote awareness of health issues and health care opportunities and the full spectrum of VA benefits. Some VAMCs began these outreach activities before RVOEC teams were funded as local initiatives, and they continue these services, now using the RVOEC teams as their agents.

The National Center for PTSD: The Center has a number of informational pamphlets for returning veterans and their families on their Web site (*http://www.ncptsd.va.gov/*). The Web site contains the latest fact sheets and literature on the war in Iraq. Important links from the site include: *The Iraq War Clinician Guide, 2nd Edition,* and two new guides on *Returning from the War Zone: A Guide for Military Personnel and A Guide for Families* as well as the *VA Operation Enduring Freedom and Iraqi Freedom Seamless Transition Web site.*

Briefings: VA provides briefings on benefits and health care services specific to Reserve/Guard members at demobilization sites and during the military pre-separation process as well as at town hall meetings, family readiness groups, family day activities, reunion and welcome home events, and during unit drills near the home of returning Guard/Reservists. Return and deactivation of Reserve/Guard units presents significant challenges to VA because rotation is irregular and the servicemembers spend short periods at military installations prior to release to their Guard or Reserve components. For this reason, VA continues to refine and adapt traditional outreach efforts to meet the needs of those who are currently separating from service by focusing at the local armories or Reserve centers in the months following deactivation. Benefits briefings such as the transition assistance program (TAP) workshops and retirement and separation briefings are available to active duty personnel and also available to Reserve/Guard members.

Following is a summary of briefings held specifically for Reserve/Guard members:

Reserve/Guard Briefings

Fiscal Year	Briefings	Attendees
2003	821	46,675
2004	1,399	88,366
2005	1,984	118,658
2006	1,298	93,361
2007*	447	23,389

*Through 01/31/07

A Summary of VA Benefits for Guard and Reserve Personnel—IB–164: VA, in cooperation with the Department of Defense (DOD), produced a new brochure outlining benefits and services available to Guard and Reserve personnel. Supplies have been mailed to regional offices to support outreach events and personal interviews. The brochure has also been provided to Reserve/Guard units to have available for members.

Secretary's Letter: Since May 2005, as part of the Secretary's Letter Writing Outreach Campaign, over 658,000 letters were mailed to veterans informing them of VA's wide range of health care benefits and assistance to aid in their transition from active duty to civilian life. Based on lists routinely provided by DOD, the Secretary of Veterans Affairs sends a letter to each returning OEF/OIF veteran, including Reserve/Guard members, who has separated from the active duty. Two pamphlets are enclosed with the letter: VA Pamphlet 21–00–1, A Summary of VA Benefits, and VA IBlO–164, A Summary of VA Benefits for National Guard and Reserve Personnel.

Veterans Assistance at Discharge System (VADS): The VADS process generates the mailing of a "Welcome Home Package" that includes a letter from the Secretary, VA Pamphlet 21–00–1, A Summary of VA Benefits, and VA Form 21–0501, Veterans Benefits Timetable, to all veterans recently separated or retired from active duty (including Reserve/Guard members). VADS also sends a 6-month follow up letter with the same enclosures to these veterans. Through this process, information letters and materials are also sent about Education and Life Insurance benefits.

About 181,000 of more than 689,000 GWOT veterans have filed a claim for disability benefits either prior to or following their GWOT deployment (approximately 26 percent). This includes survivors' claims for dependency and indemnity compensation (DIC) and death pension. VA has processed nearly 2,000 DIC claims for survivors of GWOT servicemembers who died in service.

Summary counts of C&P benefit activity among veterans deployed overseas in support of GWOT have been generated. Through this VA/DOD data match, we are at this point only able to identify deployed GWOT veterans who have also filed a VA disability claim *either prior to or following their GWOT deployment*. Many GWOT veterans had earlier periods of service, and filed for and received VA disability benefits before being reactivated. VBA's computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment.

Question 20. Committee staff have learned that separating servicemembers in the Benefits Delivery at Discharge Program are not receiving specialty examinations, except for hearing and psychiatric cases, and that VBA Regional Office personnel believe that they are precluded by policy to authorize these examinations. Please explain the bases for this policy, with specific regard to whether it is based upon budget implications, and describe your efforts to remedy the problem.

Response: There is no centralized policy that prohibits rating specialists from ordering specialty or specialist examinations when needed for servicemembers going through the Benefits Delivery at Discharge (BDD) process.

We believe that some confusion may exist over the use of the term "specialty." There are differences between general medical examinations, "specialty examinations," and "specialist examinations." A specialist examination is an examination conducted by a clinician who specializes in the particular field. Currently, all initial psychiatric examinations, and all audiology, dental, and eye examinations are required to be conducted by a specialist.

A specialty examination is an examination that may be conducted by a licensed clinician using specific detailed examination worksheets to elicit the information needed with respect to a specific disability. For example, it is not necessary in most cases to have a board-certified orthopedic surgeon or sports medicine physician conduct an examination of a knee to determine limitation of motion, stability, and other factors required by the rating schedule. Rather these are routine examinations that

occur in clinical practice throughout public and private healthcare settings by general practitioners, physicians' assistants, and nurse practitioners.

A general medical examination is one that is ordered in initial claims. It is frequently accompanied by specific specialty worksheets depending on the nature of the conditions claimed.

Question 21. We have seen a dramatic increase in the number of young veterans requiring long-term care due to combat injuries, such as traumatic brain and spinal cord injuries. How does the budget address these additional long-term care demands.

Response: VA has not seen a dramatic increase in the number of OEF/OIF veterans returning with injuries requiring long term care relative to the total veteran population receiving long term care services. However, we have seen that the OEF/OIF veteran requires increasingly complex long term care. To meet their complex care needs, VA has and will continue to provide a spectrum of long term care services for young veterans with combat injuries with the goal of maintaining them at their highest functional level and as close to home as possible. The spectrum of services ranges from home and community based care including home telehealth, respite services, and adult day health care, to three venues of nursing home care.

VA has rapidly expanded the capacity of its non-institutional home and community-based services since 1998 while sustaining capacity in nursing home programs. The Fiscal Year 2008 President's Budget Submission proposes funding for a 26 percent expansion in home and community based care services from Fiscal Year 2007 to Fiscal Year 2008. The increase will allow VA to purchase day health and independent living skills services which are designed to meet the needs of younger veterans and serve as an alternative to institutional care. In addition, sufficient capacity exists in the VA, community nursing home, and State veterans home programs to meet the needs of this population when short-term or long-term (greater than 90 days) nursing home care is indicated.

Question 22. How are education and training programs for all VA employees, specifically those regarding information protection, funded and administered?

Response: Development of training and awareness programs focused on information protection are centrally funded through the Enterprise Cyber Security Program. It provides general security awareness training for employees and specialized, role-based training for executives, project/program managers, and field chief information officers (CIO). Specialized training for Department information security officers (ISOs) and other IT professionals is centrally developed in a number of modalities, to include:

- Web-based, online modules;
- Training videos;
- Satellite broadcasts;
- Annual information security conference;
- Commercially available training, such as, security certification classes; and
- Specialized training focused on new security tools and technologies under development or being deployed in the enterprise.

We are currently assessing the option of using an Information System Security Line of Business Shared Service Center as a general security awareness training provider. This initiative is an E-Government Line of Business, managed by the Department of Homeland Security, intending to make Government-wide IT security processes more efficient.

VA policy requires all staff, including volunteers and contractors, to participate in an annual awareness session. It is the responsibility of employees and their supervisors to ensure compliance. Training metrics are collected annually and reported to Office of Management and Budget as part of the annual FISMA report. Privacy training, which also addresses information protection, is handled in a similar manner, administered through an enterprise privacy program also under the direction of the VA CIO. Privacy training is required for all employees annually and is offered in a number of modalities, including specialized role-based training courses in addition to general awareness. Privacy officers are provided with specialized training during the annual information security conference.

Question 23. I have been impressed by the establishment of risk management and incident response teams, as part of the new information protection measures VA has implemented. Under which budget line are these teams funded? Are the team members VA employees or contracted employees?

Response: As part of the Office of Information and Technology (OI&T) realignment, and as recommended by IBM, several existing IT compliance programs have been consolidated into the Office of IT Oversight and Compliance. This organization is designed to strengthen and enhance VA's records management, privacy and IT

security programs and practices through a comprehensive program of assessments. Assessment teams, comprised of VA employees, will conduct analyses nationwide to measure how well VA facilities comply with legislative, Federal Government oversight, and VA policies, procedures and practices. The major objectives of these assessments are to determine the adequacy of internal controls; validate compliance with laws, policies and directives; ensure proper safeguards are maintained; and recommend corrective actions where necessary. This office is currently funded from multiple line items within the OI&T budget, including the cyber security and privacy programs.

Question 24. Please provide a breakdown of the Fiscal Year 2008 request for all programs and services for homeless veterans, including comparisons to the levels as passed in H.J. Res. 20 for Fiscal Year 2007.

Response: The estimate for 2007 and 2008 President's budget request shows an increase in funding for Fiscal Year 2007 and Fiscal Year 2008:

Homeless Veterans Programs

	2006	2007	2008
Obligations ($000):			
Homeless Veterans Treatment Costs	$1,448,769	$1,514,096	$1,634,086
Programs to Assist Homeless Veterans:			
Health Care for Homeless Vets (HCHV)	56,998	59,278	61,649
Homeless Grants & Per Diem Program	63,621	92,180	107,180
Homeless Grants & Per Diem Liaisons		12,300	12,300
Domiciliary Care for Homeless Veterans	63,592	72,702	75,610
Compensated Work Therapy/Transitional Residence (CWT/TR) Program	19,529	20,310	21,123
Department of Housing & Urban Development/VA Supported Housing Program (HUD–VASH) & Joint HUD/Health & Human Services/VA Supported Housing	5,297	5,498	5,718
Other	1,248	3,353	3,428
Total	$210,285	$265,621	$287,008

The "other" category includes a distribution of funds for "Stand Downs"; the monitoring and evaluation performed by the North East Program Evaluation Center (NEPEC); the administration of the multifamily transitional housing loan guarantee program, and excess equipment and clothing distributed at "Stand Downs" and other homeless functions.

VA will continue with activation of 11 new homeless domiciliary residential rehabilitation and treatment programs (DRRTPs). The 11 new DRRTPs will add over 400 new rehabilitative care beds for homeless veterans.

VA will also continue the development of transitional housing and supportive service centers to fill treatment and housing gaps for homeless veterans in an overall Federal housing continuum. Public Law 107–95 provides VA the authority under the homeless providers grant and per diem (GPD) program to assist with operational costs as well as partial capital costs to create and sustain transitional housing and service programs for homeless veterans. Additionally, VA will continue to work with grant and per diem recipients to assure high-quality services and improved outcomes for homeless veterans served in these supported housing programs and supportive service centers.

In Fiscal Year 2007 and Fiscal Year 2008, VA intends to continue to work toward building on initiatives that were started in 2005 and continued in 2006. This includes continued collaboration with other Federal agencies to address the needs of homeless veterans, particularly those who are chronically homeless.

Question 25. With regard to the Grant and Per Diem Program and Special Needs Grants, the proposed budget requests $107 million in obligations and 2 FTE. Last year, Public Law 109–461 authorized $130 million for the Grant and Per Diem Program, noting that 400,000 veterans will experience homelessness at some point during the course of the year, that only 25 percent of that number receive assistance through VA, and that only 150,000 homeless veterans are served by community-based organizations each year. Please explain why more funding was not requested for these programs?

Response: VA has supported a significant increase in services for homeless veterans. VA's Fiscal Year 2008 budget requests an increase of nearly 77 million dollars between Fiscal Year 2006 and Fiscal Year 2008 funding levels. VA's plans have been both aggressive and thoughtful. VA has in recent years expanded programs so

that there are community operated programs approved in every state and Puerto Rico, and several programs on tribal land. On Thursday February 22, 2007, VA published a series of notices of funding availability (NOFA) in the Federal Register that will request proposals from community providers to create 1,000 new transitional housing beds under the VA's Homeless Providers GPD program which represents a 10 percent increase of current capacity in the number of beds; a funding opportunity to double our services for special needs programs for homeless women veterans with children, frail elderly, terminally ill and chronically mentally ill; and to offer technical assistance to assist community groups be more effective in securing additional resources.

Question 26. Last year, Congress authorized (in P.L. 109–461) appropriation of $7 million for Fiscal Year 2007 through Fiscal Year 2011 for Special Needs Grants (women, frail elderly, terminally ill or chronically mentally ill). What amount has been targeted for Special Needs Grants in the Fiscal Year 2008 budget?

Response: VA has announced a total of $6 million for current special needs and an additional $6 million for new special needs programs. The approximate amount of $12 million will be available January 2008 thru September 2009 (21-month funding cycle). VA has announced funding to renew and create new special needs grants.

Question 27. Last year, GAO reported that they estimated a 9,600 bed shortfall would occur in the number of beds available to veterans seeking to escape homelessness. How does the proposed budget address this projected need?

Response: VA's current NOFA published February 22, 2007, will add an additional 1,000 beds. Last year VA awarded funding for an additional 800 beds. In less than 6 months VA has added and offered funding to create 1,800 new beds—nearly 20 percent of beds identified in the 9,600 bed deficit identified in the last community assessment of need. VA hopes to offer additional funding under VA's Homeless Providers GPD program.

Question 28. Does the VA budget reflect any plans to expand the supply of decent and affordable housing for elderly and low-income veterans?

Response: VA does not have any authority to independently expand affordable housing for elderly and low-income veterans. VA works closely with the Department of Housing and Urban Development (HUD) and other Federal, State, and local entities to promote enhanced housing opportunities for elderly and low income veterans. Under the Enhanced Use Lease Program VA has entered into leases with other entities to create affordable transitional and permanent housing opportunities for the homeless and elderly. In VA's Enhanced Use Lease Report dated January 2007, VA has awarded 48 enhanced use leases. A total of 15 projects (37 percent) provide direct service to veterans; 9 projects provide homeless and transitional housing services, 4 projects are targeted for senior services, and 2 projects targeted for hospice care and triage emergency services. The total estimated value of the enhanced use lease agreements for both the homeless and senior services is in excess of 20 million with the conservative estimate of 682 affordable housing beds. The number is expected to increase.

Question 29. What has been budgeted for the thousands of vacant lots that could be used to stimulate the development of affordable housing for veterans?

Response: VA does not specifically budget for the development of veterans housing on VA property. However, VA does continually identify its unneeded assets (land and buildings) and uses its Enhanced-Use Lease (EUL) authority to out-lease targeted properties and/or buildings to non-VA entities, who then provide a wide-range of housing opportunities for veterans. Through this approach, VA has been able provide homeless, transitional, and affordable housing for veterans. To date, VA has executed 13 EUL projects and has 9 other EUL projects under development, which have or will include homeless, transitional or affordable housing. All aforementioned VA projects offer housing opportunities to veterans at discounted rates. VA does not currently have the authority to build and operate affordable housing facilities on VA property outside of the EUL program.

In addition to the EUL program, properties acquired by VA as the result of foreclosure of guaranteed loans made to veterans, are offered for sale to the general public in an effort to recover as much of the Government's monetary outlay as possible. If there are competing purchase offers from a veteran and non-veteran for the same dollar amount, VA gives preference to the veteran's offer. Also, the Loan Guaranty Program has the authority to sell its foreclosed properties for up to a 50 percent discount to HUD approved homeless providers who agree to use these properties primarily to house homeless veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO HON. R. JAMES NICHOLSON, SECRETARY, DEPARMENT OF VETERANS AFFAIRS

VA HEALTH CARE ISSUES

Question 1. In West Virginia private roundtables with returning veterans, I hear serious problems about the transition from military to civilian life. Would VA consider an ombudsman or a specific office so veterans had a place to seek expeditious action on claims that have fallen through the bureaucratic cracks?

Response: The Department of Veterans Affairs (VA) has taken significant measures to expedite the claims process for all Operations Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans. Each regional office has designated specific veterans service center employees to process OEF/OIF claims and an OEF/OIF coordinator to ensure that OEF/OIF claims are expeditiously processed. Any OEF/OIF veterans experiencing problems should contact their local regional office on our nationwide tollfree number 1–800–827–1000. All public contact employees have been fully trained in this special OEF/OIF processing initiative and will assure their claims receive priority handling.

Since the onset of the combat operations in Afghanistan and Iraq, VA has provided expedited and case-managed services for all seriously injured OEF/OIF veterans and their families. Last month, the Secretary of Veterans Affairs announced a new initiative to provide priority processing of all OEF/OIF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OEF/OIF theatres or in support of these combat operations, as identified by the Department of Defense (DOD).

Each regional office has designated an individual who reports directly to the director of the regional office to work with National Guard and Reserve units to obtain service medical records and serve as the primary point of contact with VA medical centers and contractors to expedite the scheduling and reports of medical examinations. The Veterans Benefit Administration (VBA) is also working with the Veterans Health Administration (VHA) and VA's contract medical examination provider to develop procedures for expediting VA medical examinations for all OEF/OIF veterans who served in or in support of OEF/OIF theatres.

To assist the regional offices in processing OEF/OIF claims, VA has also designated two development centers and three resource centers as a special "Tiger Team." The two development centers, located in Roanoke and Phoenix, will obtain the evidence needed to properly develop the OEF/OIF claims. The three resource centers, located in Muskogee, San Diego, and Huntington, will rate OEF/OIF claims for regional offices with the heaviest workloads.

Question 2. What action will the VA take during this budget cycle to ensure that the full amount of funding appropriated for mental health services is used and appropriately targeted?

Response: Appropriated funding for mental health services to VHA consists of two components. The first component is mental health funding in the amount of $2.50 billion that will be distributed to the Veterans Integrated Service Networks (VISN) in fiscal year (FY) 2007 through the Veterans Equitable Resource Allocation (VERA). The second component is mental health enhancement funding, in the amount of $306 million, to support the implementation of the Comprehensive Mental Health Strategic Plan.

To ensure that the funds are used efficiently in fiscal year 2007 and fiscal year 2008, VHA has adopted a 2-year planning period and staggered the implementation of programs during the course of the year to simultaneously prepare for the fiscal year 2007 and fiscal year 2008 initiatives.

Many of last year's delays were due to difficulties associated with hiring mental health professionals. In addition, the delay was related to both program and staff development activities that were necessary to ensure that funds, when spent, would be used effectively and efficiently to improve care. This year, to encourage prioritizing hiring for new positions, VHA has created a performance measure for VISN leadership to fill these positions. VHA is closely monitoring recruitment and the resulting changes in clinical productivity. If there are delays in hiring, VHA will use these funds to augment non-recurring projects to enhance care and advance implementation of the Mental Health Strategic Plan.

Question 3. What plan does VA have to support the Vet Centers and the staff who are dealing with an increasing number of veterans and families?

Response: VA has addressed the need for Vet Center support in anticipation of OEF/OIF requirements.

In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Center program has hired additional staff and opened new Vet Cen-

ters. In February 2004, 50 Global War on Terror (GWOT) veterans were hired to augment existing Vet Center staff. VA authorized a new 4-person Vet Center in Nashville, TN in November 2004. An additional 50 GWOT veterans were hired in April 2005 to further enhance services to veterans returning from combat in Afghanistan and Iraq. VA established two new Vet Centers (Atlanta, GA and Phoenix, AZ) in April 2006.

In February 2007, a major expansion of the Vet Center program was announced. There will be 23 new Vet Centers located in Montgomery, AL; Fayetteville, AR; Modesto, CA; Grand Junction, CO; Orlando, Fort Myers, and Gainesville, FL; Macon, GA; Manhattan, KS; Baton Rouge, LA; Cape Cod, MA; Saginaw and Iron Mountain, MI; Berlin, NH; Las Cruces, NM; Binghamton, Middletown, Nassau County and Watertown, NY; Toledo, OH; Du Bois, PA; Killeen, TX; and Everett, WA.

Since the inception of the Vet Center bereavement program in fiscal year 2004, the families of over 900 military casualties have received bereavement services. Of these 900 cases, almost 75 percent of the casualties were from OEF/OIF. Through this program, Vet Centers have provided approximately 6,500 visits to families at an estimated cost $600,000. The capacity for an increase in current workload was factored into the current budget.

Question 4. Does the VA has any plans underway to provide additional training and support for staff and veterans on the issue of suicide prevention as suggested by S. 479, the Joshua Omvig Veterans Suicide Prevention Act?

Response: VHA has formulated a comprehensive strategy for suicide prevention focusing on the needs of both new veterans from OEF/OIF and those from prior conflicts.

The specific programs for suicide prevention are based on public health and clinical models, and activities both within the community and in VA facilities.

Structural elements of the program include:

- Designation of March 1, 2007, as the first annual VA National Suicide Prevention Awareness Day with educational activities for all staff, clinical and non-clinical at all VAMCs.
- Designation of two Centers of Excellence focused on suicide prevention that will provide technical assistance to the system as a whole.
- Designation of the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) to maintain data on suicide rates and risk factors, nationally, regionally, and locally, to guide prevention strategies.
- Funding for Suicide Prevention Coordinators within each VA medical center as of April 1, 2007.
- Creation of a suicide prevention hotline for veterans by the end of this calendar year.

Public health oriented components of the program, to be accelerated during the coming year, include:

- Ongoing messages and education for the community about the availability of services and the effectiveness of treatment.
- Continued outreach to returning veterans to support awareness of VA resources and identification of mental health concerns.
- Increasing training for those who are in contact with veterans about the recognition of signs and risk factors for suicide, and process for helping veterans engage in treatment.
- Strengthening collaborations with other local, regional, and national suicide prevention activities.

Clinical components of the program include:

- Education and training for all VA staff about signs and risk factors of suicide, and of opportunities to help veterans in need engage in treatment.
- Programs organized and directed by the suicide prevention coordinators to identify veterans at high risk for suicide and to ensure that the intensity of their clinical monitoring and care are enhanced.
- Training for all mental health providers on evidence-based interventions shown to prevent suicide.

SECURITY QUESTIONS

Question 5. How is the Department of Veterans Affairs (VA) addressing the protection of Personally Identifiable Information (PII) as described in the Executive Office of the President, OMB Memorandum M–06–16?

Response: VA is taking the following actions to address the protection of PII:

1. Encrypt all data on mobile computers/devices which carry agency data unless the data is determined to be non-sensitive, in writing, by your Deputy Secretary or an individual he/she may designate in writing;

By September 15, 2006, the VA encrypted approximately 15,000 laptops. To date, the VA has 18,000+ laptops that are encrypted. Simultaneously, the Department developed and implemented procedures to ensure that all laptops have applied updated security policies and removed all sensitive information that was not authorized to be stored on the devices. This procedure will continue to occur throughout the Department routinely and is one measure we have undertaken to protect information.

The VA Secretary recently approved VA Directive 6600, Responsibility of Employees and Others Supporting VA in Protecting Personally Identifiable Information (PII) , and VA Directive 6601, Removable Storage Media. VA Directive 6601 mandates that VA will only allow Federal Information Processing Standards (FIPS) 140–2 certified encrypted universal serial buses (USB) thumb drives to be used within the Department. In addition, a port security technology is currently undergoing test and evaluation to enforce adherence to the directive. This technology will only allow VA authorized removable storage media to be used; it will restrict the transfer of information to removable storage media, and will thwart the introduction of malicious code via USB ports.

The VA is also establishing levels of standardization for Blackberry devices, SmartPhones and other mobile devices. Older versions of mobile devices that do not support encryption or content protection will be retired and replaced with versions of the devices that can support the VA's IT security policies. The Department has Implemented Blackberry content protection on a majority of devices VA owns. IT Memorandum 07–01, Standardization of Blackberry Devices SmartPhones and other Mobile Devices, also restricts the usage of non-government mobile devices within VA and only allows them to be used if the VA can monitor their use to verify that they are following VA IT Security policies. The VA is also in the process of deploying Trust Digital which will encrypt SmartPhones.

2. Allow remote access only with two-factor authentication where one of the factors is provided by a device separate from the computer gaining access;

The Virtual Private Network (VPN) currently uses the active directory (AD) infrastructure for VPN authentication. Once connected to the VA network, access to sensitive data usually requires additional authentication to the internal resource that hosts the information. The Network Security Operations Center (NSOC) is in the process of writing a white paper regarding an interim implementation of two-factor authentication, pending the rollout of VA's personal identity verification (PIV) project.

3. Use a "time-out" function for remote access and mobile devices requiring user reauthentication after 30 minutes inactivity;

The "time-out" function has been in place since the VPN was implemented in January 2002. Users are disconnected if their VPN session is inactive for 30 minutes. If they choose, they may initiate a new VPN connection which requires them to reauthenticate. In order for an inactivity timer to be enforced, there must be no traffic generated over the connection. There are many applications that send out "heartbeats" and "keep-alives" or that routinely generate traffic (i.e. Outlook) that prevent a VPN session from being inactive. When these types of applications are running with VPN, the inactivity timer cannot be enforced.

4. Log all computer-readable data extracts from databases holding sensitive information and verify each extract including sensitive data has been erased within 90 days or its use is still required.

The VA has developed an enterprise level requirements document that was submitted to the vendor community in March 2007 for a request for information (RFI). Among the many types of requirements, this document is intended to address business requirements for protecting information, such as the mandate from the Office of Management and Budget (OMB) 06–16 "to log all computer-readable data extracts databases holding sensitive information and to verify each extract including sensitive data has been erased within 90 days." In response to the RFI, the vendor community will provide technology solutions for VA to research, test, and deploy. Technology to address OMB 06–16 will result from the RFI. The Department will take immediate action subsequently to begin test and evaluation of the technology.

Question 6. What specific policy, plans, and funding has the VA put in place to ensure all of the following OMB M–06–16 requirements are met and that protection of all personally identifiable information is secure and cannot be compromised?

Response: Several Departmental policies have been issued from the Secretary and Deputy Secretary:

SECVA Directives

VA IT Directive 06–2, Safeguarding Confidential and Privacy Act-Protected Data at Alternative Work Locations, dated June 6, 2006.

Memorandum for the Assistant Secretary for Information and Technology, Delegation of Authority for Responsibility for Departmental Information Security, dated June 28, 2006.

Open Letter to VA Contractors and Subcontractors, dated August 10, 2006.

DEPSEC Directives

VA IT Directive 06–1, Data Security–Assessment and Strengthening of Controls, dated May 24, 2006.

Memorandum to Under Secretaries, Assistant Secretaries, and Other Key Officials—Access Control and Employee Sensitivity Levels, dated July 14, 2006.

Memorandum to Under Secretaries, Assistant Secretaries, and Other Key Officials—Handling and Storing of VA Data by Contractors and Subcontractors, dated August 10, 2006.

VA IT Directive 06–3, Data Security–Assessment and Strengthening of Controls, Review of VA Activities that Involve Non-VA employees, dated August 11, 2006.

VA IT Directive 06–4, Embossing Machines and Miscellaneous Data Storage Devices, dated September 7, 2006.

VA IT Directive 06–5, Use of Personal Computing Equipment, dated October 5, 2006.

VA IT Directive 06–6, Safeguarding Removable Media, dated September 29, 2006.

VA IT Directive 6600, Responsibility of Employees and Others Supporting VA in Protecting Personally Identifiable Information (PI), dated February 27, 2007.

VA IT Directive 6601, Removable Storage Media, dated February 27, 2007.

The VA NSOC has architected a new remote access environment that distinguishes VA government furnished equipment (GFE) from non-VA owned other equipment (OE). GFE equipment is subjected to a variety of compliance and host integrity checks. One of those checks includes ensuring the remote device is encrypted prior to allowing full access to the VA network. Non-encrypted devices will be restricted to a virtual desktop which does not allow data to be saved on the unencrypted device. The NSOC is preparing to begin a 60-day pilot of this solution March 12, 2007. This new architecture will include a 30-minute inactivity timeout which requires the user to reauthenticate if they wish to reconnect to the VA network. The solution is also capable of supporting two-factor authentication.

While the Department is in the process of testing, evaluating, procuring and deploying at an enterprise level, the technologies that exist within VA that contribute to Information Protection, a long term strategy has been developed and is being executed in parallel.

The long term strategy began with the development of an enterprise information protection requirements document. The existing infrastructure serves as a baseline for VA's information protection program and the intent of the requirements document is to fill in the gaps where information is stored and transmitted, that have yet to be addressed because VA does not have the technology. The intent of the RFI is to have the vendor community feed information back to VA with recommendations on how VA can fill in the information protection gaps with technical solutions to mitigate the likelihood of unauthorized disclosure.

VA has already procured the software to encrypt laptops, Blackberry devices and SmartPhones and will procure FIPS 140–2 certified thumb drives, as needed. The secure remote access solution, the port security solution and the secure network transmission technology will be funded and procured with fiscal year 2007 money if pilot testing proves successful. Funding has been made available to support all of VA's information protection initiatives.

Question 6(a). What is the status of ensuring that all data on portable devices is encrypted before leaving the physical premises of the VA?

Response: When the Department encrypted the laptops in September 2006, a laptop health check procedure was implemented throughout the enterprise. The Department developed and implemented procedures to ensure that all laptops have been encrypted, all security policies are updated and all unauthorized sensitive information has been removed from the devices. This procedure occurs routinely throughout the Department and at a minimum; laptops must be brought into the facility every 90 days to undergo the health check. In addition, VA IT Directive 6601 mandates that all information stored on a removable storage media must be stored on a device that employs the National Institute of Standards and Technology (NIST) (FIPS) 140–2 certified encryption algorithms.

Question 6(b). What is the status of ensuring that all remotely accessed data is only available to users who have verified at least 2 factors of authentication, and that access is revoked after 30 minutes of inactivity?

Response: VA has an enterprise-wide VPN solution. The VPN currently uses the VA AD infrastructure for VPN authentication which is one-factor authentication. There is, however, a separate "authorization" component to the authentication process. A database that contains authorized VPN users is maintained by information security officers (ISOs). If a user is not in the database, they will not be authorized access to the VA network, even if they possess a valid AD account. Also, once connected to the VA network, access to sensitive data usually requires additional authentication to the internal resource that hosts the information. The NSOC is in the process of writing a white paper regarding an interim implementation of two-factor authentication, pending the rollout of the PIV project. All One-VA VPN users are subject to a 30-minute inactivity timeout.

Question 6(c). Are you successfully enforcing the removal of all remotely stored data over 90 days old?

Response: For data that is stored on laptops, the information should be removed during the routine 90 day health check. VA is in the process of deploying Microsoft Rights Management Services (RMS) throughout the enterprise. This technology will automate the process of ensuring information is removed after 90 days of being stored. The implementation of Microsoft RMS will allow VA to protect information that has been used and stored remotely. RMS has the ability to set the duration for how long documents, files and e-mails can exist and then the document will automatically be destroyed after the duration is expired. RMS will be fully implemented throughout the enterprise by July 2007.

Question 6(d). Once all this security is in place, will employees be able to get their work done remotely—that is, can they access e-mail, get to files and applications on PCs and servers, and communicate with coworkers, regardless of location?

Response: Each of the technologies that VA is implementing contributes to Information Protection and they integrate so that business operations can continue. E-mail access remotely for employees, contractors and business partners using GFE will be accomplished through the use of the GFE VPN solution. The GFE VPN solution will allow employees to access e-mail and share drives to conduct business. E-mail for employees, contractors and business partners with OE can be accomplished through the use of Outlook Web Access (OWA) and a virtual desktop. The virtual desktop will allow OE employees to access the intranet and work with files and documents; however, nothing can be saved on the device. The VA also has a technology undergoing test and evaluation to encrypt network traffic. This technology will ensure that the traffic from VistA mail, computerized patient record system (CPRS) and time and attendance applications are encrypted. The technology can provide a secure encrypted connection, with secure sockets layer (SSL) 3.0/TLS 1.0, from an external system to the internal server. This technology, coupled with the use of OWA and secure VPN will enable employees to conduct business on external devices in a secure manner.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO HON. R. JAMES NICHOLSON, SECRETARY, DEPARMENT OF VETERANS AFFAIRS

SPOKANE ER: SHORTER HOURS AT VA URGENT CARE IN SPOKANE

Question 1. Mr. Secretary, this is a second problem with the VA's emergency room policy. It is very hard for veterans to figure out if the VA is going to pay for an ER visit or if they're going to get stuck with the bill. Your new director for emergency medicine, Dr. Gary Tyndall, told the *Syracuse Post Standard*—"I've told patients 'You could have died from this.' And the veterans will say, 'I'd rather die than leave my family with a bill that would take 5 years to pay.'"

Mr. Secretary, if veterans are not going to the ER because they're worried about sticking their families with massive bills, then it's clear your policy is broken. I think part of the problem is that the rules are very confusing. The VA is the "payer of last resort." And whether or not it pays depends on everything from the miles to the hospital, the veteran's age, whether its service connected, and the time of day.

Response: VA is aware that the statutes and regulations for emergency care can be confusing to veterans and providers. We are taking the following steps to address these concerns:

- Providing an emergency care brochure to all local VA facilities, that is also available on VA's Web site.

• Developing handbooks explaining Fee program regulations and policies, which will be made available to the general public on the VA Web site.
• Providing training to all VA Fee program staff so they can better explain the requirements for payment of emergency care. VA's long term goal is to clarify and simplify all regulations for the Fee program.

CONFUSING ER PAYMENT MAKES VETERANS HESITANT TO SEEK CARE

Question 2. Mr. Secretary, there is a major concern in the eastern part of my state about emergency care for veterans. In Spokane, at least one veteran has died when he sought care at a VA hospital that no longer offered urgent care after 4:30 p.m. According to the *Spokesman Review*, two other families have come forward saying the same thing happened to their loved ones. Mr. Secretary, that is absolutely unacceptable. When a veteran is having chest pains, he should not have to wonder whether the doors to the VA are going to be closed to him or have to worry about getting stuck with the bill if he goes to a local hospital. Why did you reduce the hours of urgent care at Spokane VA?

Response: For many years, the Spokane VAMC provided around-the-clock emergency room care for veterans; however, after a long-term review of clinic records, it was determined that very few patients actually used the emergency room after regular business hours. The review also showed that treatments provided to those patients who did come in for after-hours services were mostly for minor, non-urgent conditions that could have safely been taken care of the next business day.

These findings raised concerns regarding physicians keeping their skills current with such a low volume of patients presenting for care with the vast majority having minor ailments. In addition, the facility determined that resources dedicated to after hours activities should be realigned to daytime services in order to provide better and faster care to our patients. This change also allowed the facility to expand their ability to see as many veterans as needed on a daily basis.

Question 2(a). What are you doing to fix this broken and confusing emergency room policy?

Response: VHA recognized the importance of establishing clear emergency room policy and established The Emergency Medicine Field Advisory Committee, (EMFAC) to actively assess and improve the provision of emergency care in our facilities. As a result of the EMFAC's efforts, VHA Directive 2006–051, "Standards for Nomenclature and Operations in VHA Facility Emergency Departments," dated September 15, 2006, was published. This directive establishes policy ensuring that emergency departments at VHA facilities remaining open 24 hours a day delivering high-quality emergency care. It also outlines the minimum standards that are acceptable for emergency departments that provide emergency care to our veteran population and the appropriate designations for units providing unscheduled care to veterans, i.e., emergency department and the urgent care clinic. National implementation of this policy is underway.

Question 2(b). What are you doing to communicate with local veterans in Spokane so they know the VA does not provide urgent care after 4:30 p.m.?

Response: Prior to the reduction in urgent care hours (June 2006), an aggressive communication plan was launched in an effort to educate veterans, not only about the change in hours, but about where to seek care in the case of an emergency. The plan included a direct mailing to 23,000 patients, advising them of the change in hours and encouraging them to go directly to community emergency rooms if emergency care is needed. Less than a dozen veterans responded to the letter, with most seeking confirmation that their service connected needs would be paid by the VA.

Veterans were also informed that, as a result of the change in hours, Spokane's telephone care program was expanded, and treatment for urgent or emergent conditions related to their service-connected condition, or veterans with no other payment source who meet certain criteria, may be eligible for payment assistance through a VA program. In addition, a brochure detailing urgent care hours, services and instructions regarding what to do in the event of an emergency, was widely distributed to veterans during the time of the change.

In October 2006, a second letter was sent to the same 23,000 patients, reiterating the information contained in the first letter. The second mailing also included a fact sheet addressing eligibility questions. In addition, public service announcements were distributed to media outlets in Spokane and the surrounding area, detailing the change in hours, clarifying the types of services provided at the urgent care unit, describing the most common symptoms of a life threatening emergency, and urging veterans to go to a community emergency room, regardless of the time of day, should they experience a health emergency. The telephone line at the Spokane

facility also directs patients that, in case of emergency, they are to "hang up and dial 911 immediately."

WALLA WALLA

Mr. Secretary, turning to Walla Walla, Washington—As you know, in 2003 the VA CARES Commission tried to close the facility that 69,000 veterans rely on. I worked with the community and the VA, and I appreciate you committing to building a new facility in Walla Walla. The community and I have some questions about the care that will be provided in that new facility—particularly mental health, long-term care, and inpatient medical care.

Mental Healthcare

Question 3. As you know, mental health care is not available in the surrounding community. Can you explain how veterans in Walla Walla will get mental healthcare under your proposal? Also, how will they get drug rehabilitation?

Response: The VAMCs in Walla Walla and Spokane will cooperatively manage inpatient mental health care for the Washington, Oregon and Idaho counties in their 38 service areas. This will include residential rehabilitation care for substance abuse and PTSD provided mostly at the Jonathan M. Wainwright Memorial VAMC in Walla Walla and through community contracts in Spokane. Inpatient psychiatry will be provided at the Spokane VAMC in Spokane, Washington and through community facilities in Lewiston, ID, and Yakima and Tri-Cities, Washington. Expanded outpatient mental health services will continue to be provided at the VAMCs, the existing and planned community based outpatient clinics, and in other locations as determined.

Question 4. Will you continue to provide long-term care at the Walla Walla facility as long as it's needed, and will you commit to working with the state to build a state nursing home?

Response: Long term care will be provided at the Walla Walla facility or the surrounding community as long as it's needed. In regards to working with the state to build a state nursing home, VISN 20's network director has recently requested that Walla Walla's new director work with the director of the Washington State Department of Veterans Affairs to begin the process of establishing a nursing home. Applications for VA grants to assist in the construction of state nursing homes for Fiscal Year 2008 must be submitted by August 15, 2007.

Question 4(a). How should vets who need LTC today get it?

Response: There has been no change in the provision of long term care at the Walla Walla facility at this time.

INPATIENT CARE

Question 5. Can you assure me that veterans in Walla Walla will not lose access to inpatient care as this transformation moves forward?

Response: Veterans with service-connected conditions will continue to receive acute inpatient care in community facilities close to their homes. Walla Walla facility staff will ensure that the quality and accessibility of care are maintained.

Question 6. Mr. Secretary, Washington state is working on getting its second VA cemetery in the Spokane area. Veterans have long sought a cemetery in Eastern Washington, so survivors could avoid the 5-hour drive to the Tahoma National Cemetery near Kent, south of Seattle. Can you or Under Secretary Tuerk update me on the status of this cemetery?

Response: The staff of the VA State Cemetery Grants Program are coordinating with the State of Washington Department of Veterans Affairs to establish a State veterans cemetery in the Spokane area that will serve approximately 70,000 veterans living in Eastern Washington and Idaho. Prior to VA approving a pre-application for the grant, Washington must approve legislation that will authorize the State to apply for Federal assistance. A study conducted by the State identified two properties suitable for 39 development as a new cemetery located approximately 15 to 20 minutes from downtown Spokane. Due to the large number of veterans in the area, VA State Cemetery Grants Program staff is working closely with the State of Washington Department of Veterans Affairs on the preparation of the award request, which would grant funds to cover 100 percent of the cost of developing and equipping a State veterans cemetery.

VA BUDGET CUTS AND FREEZES SPENDING IN FUTURE YEARS

Question 7. Mr. Secretary, your budget assumes cutbacks in veterans' healthcare in 2009 and 2010 and a freeze after that. Those cuts could hit just when large a

number of troops are returning home and need care. Are these phony numbers—created to make it seem like the President's Budget is balanced?

Response: Out-year estimates in the 2008 budget are based on an OMB formula that is tied to government-wide deficit reduction targets for 2009 through 2012. Consistent with past practice, VA's medical care budget for 2009 and beyond will be evaluated on an annual basis. I fully anticipate that the President's budget in future years will include sufficient medical care resources to ensure the continued delivery of timely, high-quality health care for our Nation's veterans.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO HON. R. JAMES NICHOLSON, SECRETARY, DEPARMENT OF VETERANS AFFAIRS

COMPENSATION AND PENSION PROGRAM

Question 1. It is clear the Administration has made improving claims processing a high priority, by requesting over 450 new Compensation and Pension (C&P) employees. However, VA's productivity target for FY08—101 claims per direct FTE—is lower than VA has achieved in prior years and lower than VA expects to achieve this year. It is also substantially lower than the FY07 goal of 108—a goal that VA described last year as "realistic" given the increasing experience levels of employees hired during FY05 and FY06.

Question 1(a). What factors account for this reduction in target performance? With the increasing experience level of previously hired employees, how can VA justify lowering its productivity goals?

Response: Output per FTE is the number of completed rating-related claims per C&P direct labor FTE. Table 1 following illustrates the 2004–2006 actual output and the 2007–2008 estimated output. VA's 2008 budget submission adjusted the 2007 output target to 102.8, and the 2008 output target to 101.

Direct Compensation and Pension Rating Productivity Actual and Estimates

	C&P Direct FTE	Completed Claims	Output per FTE
2004	7,498	703,254	94
2005	7,547	788,298	101
2006	7,858	774,378	98.5
2007 (projected)	7,863	808,316	102.8
2008 (projected)	8,320	840,320	101

The primary factors for lowering the rating-related claims output for 2007 and 2008 are: the large number of new employees added in 2006 and projected to be added in 2007 and 2008; continuing loss of our most experienced decisionmakers to retirement; increased number and complexity of claimed disabilities; and changes in law and process.

In recent years, there has been a trend for veterans to claim multiple disabilities. For 2006, 24 percent of the original compensation claims contained eight or more service-connected conditions. The number of claimed conditions increases the number of variables that must be considered and addressed, therefore making the claims more complex. VCAA continues to influence the claims process. VCAA has increased both the length and complexity of claims development by increasing VA's notification and development duties to assist.

Additionally, VBA continues to expand outreach programs for separating servicemembers and is devoting resources to priority claims processing for all returning OEF/OIF veterans. VBA's outreach initiatives result in more claims.

Beginning in the second quarter of 2006, VSA began an aggressive recruitment program that has increased our on-board strength by over 580 employees (in addition to replacing all employees who retired or otherwise left VBA). These new employees require extensive and ongoing training to become effective. VBA provides on-the-job and comprehensive centralized national training for all new claims processors. However, the overall training process takes 2 to 3 years for an entry-level employee to become fully productive. Approximately 40 percent of our decisionmakers have less than 3 years of experience in their current positions. As these employees develop their skills and gain experience, their output per FTE will increase.

Question 1(b). Given the length of time it takes for new employees to become fully productive, when would VA expect to see productivity improvements based on the additional 450 FTE?

Response: The productivity assumptions for the additional 450 FTE hires are based upon outcomes from recent employment activities and the current training process. On average, due to the complexities of claims processing, an entry-level claims processor does not become fully productive until they have at least 2 years in the position. Based on that assumption, VBA anticipates some productivity improvements from the additional 450 Fiscal Year 2008 hires as early as 6 months from the employment commencement—with full production reached after 2 years in the position.

Question 2. In 2001, the VA Claims Processing Task Force—Chaired by Admiral Daniel Cooper—recommended that VA allocate FTE "to those Regional Offices that have consistently demonstrated high levels of quality and productivity in relation to workload and staffing levels." If VA's budget proposal is approved, how would VBA allocate the additional C&P FTE among the regional Offices? Will FTE be allocated only to high-performing offices?

Response: VBA's staffing policy considers both the number of claims received at a RO and specific performance factors in determining its FTE share for the Fiscal Year. FTE is allocated to all offices based on the number of claims received in order to ensure that staffing levels are maintained at a sufficient level to allow completion of the C&P work received each year. However additional FTE is distributed to ROs who demonstrate high levels of quality and productivity. These performance factors are reviewed each Fiscal Year and reflect VBA's strategy to reduce the inventory of pending claims and improve decision timeliness, decision accuracy, and appeals processing. Therefore, stations that consistently perform better in these critical areas will receive additional FTE.

Question 3. In a December 2005 report, the Government Accountability Office noted that there are wide variations in performance among the 57 VA regional offices. According to that report, "VBA and others who have studied claims processing have identified various options for changing the basic field structure in order to improve claims processing efficiency, reduce overhead costs, and improve decision accuracy and consistency, including consolidating claims processing into fewer than 57 regional offices." Would removing the claims processing function from challenged regional offices and shifting that work to high-performing stations improve VBA's overall efficiency? If so, does VA plan to implement any consolidations of this type during FY08?

Response: VBA continues to explore opportunities to improve claims processing efficiency and improve decision accuracy and consistency. The BDD program provides servicemembers with briefings on VA benefits, assistance with completing forms, and a disability examination before leaving service. The goal of this program is to deliver benefits within 60 days following discharge. VBA has consolidated the rating aspects of our BDD initiative, which will bring greater consistency of decisions on claims filed by newly separated veterans. Additionally, VBA consolidated claims based on radiation exposure to the Jackson RO. Claims based on radiation exposure require lengthy and complex evidence development prior to adjudication; consolidation of these claims to Jackson will allow quicker development due to specialization of the staff and a single line of communication to sources of information, including DOD.

We also established two Development Centers in Phoenix and Roanoke to assist ROs in obtaining the required evidence and preparing cases for decision. Pension processing realignment began in 2002 with the consolidation of pension maintenance work to Philadelphia, St. Paul, and Milwaukee. Continued consolidation of original pension work to these centers is currently under consideration. In October 2006, VBA's C&P Field Realignment Task Force presented its recommendations to the Under Secretary for Benefits. The Task Force presented three near-term recommendations currently under consideration: (1) consolidation of survivor benefit claims processing, (2) restructuring of the oversight and management of fiduciary activities, and (3) centralization of telephone activities to call centers.

The Realignment Task Force also presented recommendations to develop a comprehensive strategic plan for the longer-term consolidation of additional compensation work. As we explore and develop additional consolidation opportunities in our compensation program, we will continue in 2008 to use our resource allocation model and brokering strategy to redirect workload and resources from our challenged regional offices to our most productive stations.

Question 4. Given that the level of incoming claims has been increasing over the past several years and the ongoing conflicts in Iraq and Afghanistan, what is VA's basis for concluding that incoming claims in FY08 will remain at the same level as VA expects to receive in FY07 (800,000 claims)?

Response: In preparing our estimate for Fiscal Year 2008 we considered a number of factors. Those include the trend in disability claims over the last 10 years, the size of the active duty force, and any known or anticipated factors that would affect claims activity. At the time the budget was prepared, increased troop strengths in Afghanistan and Iraq were not certain. If the surge in forces in the combat theaters is drawing from existing active duty and already planned activation of Guard and Reserve forces, we believe we have already accounted for them. We did not predict any major changes in benefit entitlement criteria or new programs that would increase claims.

Question 5. During FY07 and FY08, how many Rating Veteran Service Representatives and Veteran Service Representatives will be eligible for retirement and how many do you anticipate will retire during those years?

Response: Through 2008, approximately 900 Veterans Service Representatives and Rating Veterans Service Representatives will be eligible to retire. We anticipate about 200 retirements each year.

EDUCATION PROGRAM

Question 1. I appreciate VA's efforts to find innovative ways to improve productivity, such as the Contract Management Support Center initiative. By having year-round contract customer service representatives handling education calls, how many additional FTE would this allow the Education Service to allocate to processing and deciding education claims? What impact would this have on the expected level of productivity?

Response: It is estimated that the contract management support center would allow the reallocation of 45 FTE to processing education claims. This represents 5.8 percent of the 772 direct FTE allocated to field stations in Fiscal Year 2008, and would be expected to result in a similar percentage increase in output.

Question 2. It is my understanding that many calls are simple inquiries about the status of a claim and that VA has been working toward providing that information online. What is the status of that effort? Once that information is available online, do you anticipate a decline in incoming telephone calls?

Response: We are currently working on providing status of claim information on our GI Bill Web site by allowing individuals to log into the Web automated verification of enrollment (WAVE) application and view status of claim information from their electronic claims folder. Our plan is to have this additional self-service feature available by July 1, 2007. Right now, if they are currently receiving benefits, they can view their current award information in WAVE and submit a change of address, if required.

We are also looking to add additional features so that individuals can view other benefit information that pertains to their individual benefit record, such as the amount of their remaining entitlement, delimiting date and payment information.

We would anticipate a decline in the number of telephone inquiries that we receive as we add more self-service options on our GI Bill Web site.

Question 3. With the additional FTE requested for the Education Service, plus any FTE that would be freed-up by using a contract call center, will staffing be sufficient to handle the expected level of incoming claims in FY08 and to reduce any existing backlog?

Response: With the 14 additional FTE requested for the Education Service, plus the 45 FTE that would be freed-up by using a contract call center, staffing will be sufficient to handle the expected level of incoming claims in Fiscal Year 2008, to reduce pending inventory, and to improve processing timeliness.

VOCATIONAL REHABILITATION AND EMPLOYMENT PROGRAM

Question 1. The Administration's FY08 budget proposal includes $4.3 million to enhance the Disabled Transition Assistance Program (DTAP).

Question 1(a). How many DTAP briefings has VA proved each year since 2001 and how many attendees were at those briefings?

Response: VA did not separately track DTAP briefings prior to Fiscal Year 2006. A breakout of DTAP briefings and participants during Fiscal Year 2006 and Fiscal Year 2007 through January as follows:

FY 2006: 1,462 DTAP briefings attended by 28,941 participants.

FY 2007 through January 2007: 493 DTAP briefings attended by 9,407 participants.

Question 1(b). With the expanded resources requested for FY08, how many DTAP briefings does VA expect to provide and how many attendees could be accommodated? At how many locations will these DTAP briefings be conducted?

Response: DOD projects that approximately 200,000 servicemembers annually will separate from active duty or be demobilized. Of those separating, approximately 35,000 will receive medical separations.

Currently, DTAP briefings are not mandated or required by all military services during the pre-separation counseling process or during medical separation. A review of Department of Army data showed that about 45 percent of separating servicemembers requested a DTAP briefing during pre-separation counseling. Extrapolating from that data, VA anticipates that about 80,000 servicemembers could potentially request a DTAP briefing. If DOD mandates that DTAP briefings be provided for all separating servicemembers who request a briefing, then VA's goal is to provide services to all 80,000.

VA proposes to use the expanded DTAP resources requested for Fiscal Year 2008 to meet this goal. The more severely injured hospitalized servicemembers will require one-on-one DTAP. Other servicemembers can receive DTAP briefings in small groups that encourage discussion and participation. We estimate that the ideal group size would be 8–12 participants. DOD has more than 300 separation sites, both within and outside the continental United States. The following groups will be used to prioritize expenditure of funds and location of DTAP briefings:

Priority Group 1: Hospitalized War-Wounded and Severely Disabled—These are the most seriously injured servicemembers in jurisdictions with major military treatment facilities. One-on-one DTAP will be provided at these locations to the servicemembers and their family members. Individual and very small group DTAP briefings will also be provided to servicemembers referred to the Military service's physical evaluation board (PEB).

Priority Group 2: War-Wounded Requiring Rehabilitation—Injured/ill servicemembers who are in medical hold or medical holdover status will be provided individual and group DTAP briefings. Servicemembers in this group will generally be in their home communities and assigned to National Guard/Reserve units, community based health care organizations (CBHCOs), MTFs, or other military separation centers.

Priority Group 3: Hidden War-Wounded: Readjustment and Coming Home—Injured veterans who have already separated from active duty or demobilized are also eligible to attend DTAP briefings. These individuals usually self-identify after sustaining "hidden wounds" during combat operations that were not identified until the PDHRA. DTAP briefings will be provided at National Guard/ Reserve units, MTFs, military installations, and VA facilities.

Priority Group 4: Other Injured/Ill Servicemembers—Other servicemembers and military retirees self-identified during DOD's pre-separation counseling process as requesting or requiring a DTAP briefing. DTAP briefings will be provided at military duty stations across the country.

Question 2. The Administration's FY08 budget proposal request 35 additional FTE for the Vocational Rehabilitation and Employment Program to serve as contracting specialist, to work on the Coming Home to Work initiative, and to work on the Process Consolidation initiative.

Question 2(a). For the Coming Home to Work initiative, what specific functions will these employees perform? How do these functions differ from those performed under the direction of the Veterans' Employment and Training Service, or other Federal employment programs?

Response: Vocational Rehabilitation and Employment (VR&E) provides a variety of services to veterans to facilitate their timely return to civilian employment (educational/vocational testing, counseling, volunteer and non-paid work experience, job accommodations, adaptive technology, job seeking assistance, job retention skills, education, on-the-job training, and all necessary rehabilitative support services). The goal is for the veteran to obtain and retain suitable employment consistent with their interests, aptitudes, and abilities. The coming home to work (CHTW) initiative currently brings these services to servicemembers on medical hold status at eight major MTFs. However, the need to provide early VR&E services to VR&E eligible servicemembers is growing. Through DOD's community based health care initiative, more and more wounded servicemembers are recovering at their home of record, and therefore do not receive all of the outreach efforts available at the MTFs. VA plans to implement CHTW at all 57 ROs by September 30, 2008, in order to meet the needs of all VR&E eligible servicemembers that will be medically separated from the military. Providing VR&E services to servicemembers on medical hold status can greatly reduce the length of unemployment many disabled veterans face after separation.

Eight FTE are requested for the CHTW program in the Fiscal Year 2008 budget submission. Those FTE will liaison with military case managers and VR&E staff, assist servicemembers with the VR&E application process as needed, and case man-

age OEF/OIF servicemember application processing. Each of the eight FTE will cover a geographical region, providing services to servicemembers at MTFs, CBHCOs, and VA facilities within their assigned region. Unlike employees of the veterans employment training service (VETS) and other Federal initiatives, these FTE will focus specifically on VR&E services.

Question 2(b). For the Process Consolidation initiative, what are the major milestones of that project and what are the target completion dates for those milestones?

Response: Milestones for the VR&E process consolidation initiative are still under development. The goal is to consolidate various VR&E functions as determined and prioritized by a thorough analysis and a feasibility assessment. Possible functions subject to consolidation and centralization include: general eligibility determination processing; subsistence allowance award processing; contract administration; purchase card processing; training; and management oversight. The Fiscal Year 2008 budget submission includes four FTE in support of this effort.

LOAN GUARANTY PROGRAM

Question 1. If I understand your request, you expect more VA-guaranteed loans to be made during the 2007 and 2008 period, and more defaults and foreclosures resulting from rising interest rates and maturing loans. Despite the workload increase, you request a reduction in the loan guaranty budget. How will VA maintain quality service to veterans in the face of a declining budget and increasing workload? If relying on industry partners is an aspect of the "do more with less" strategy, which I applaud, what oversight mechanisms are in place to ensure that taxpayers and veterans are being well served?

Response: VA will be prepared to ensure that taxpayers and veterans are well served should the Loan Guaranty program have to deal with a rise in defaults and foreclosures. A newly redesigned loan servicing business process and its supporting IT application will, among other things, allow VA to maintain high quality service to veterans, and improve VA oversight capability of private sector loan servicers. Under this new environment, many loan servicing functions are delegated to private sector loan servicers, and VA will use IT to directly oversee the work being performed by these servicers on VA's behalf.

The redesigned business environment will be managed through the VA loan electronic reporting interface (VALERI) application, which is scheduled for implementation at the end of 2007. Through use of VALERI, VA will gain significant efficiencies in servicing loans. VALERI will provide VA the capacity to directly monitor and ensure appropriate performance of servicers as they service VA loans, and will expedite VA's ability to intervene on veterans' behalf when necessary.

Question 2. Please provide me with updated statistics on the usage of ARMs and hybrid-ARMs.

Response: Between 1993 and 1996, VA had the authority to guarantee adjustable rate mortgages (ARMs). During this period, 139,271 such loans were made. Since reauthorization of ARMs in 2004, VA has made 1,695 such loans. Since receiving authority to guarantee hybrid adjustable rate mortgages in 2003, VA has guaranteed 81,319 such loans.

OFFICE OF GENERAL COUNSEL

Question 1. During the past few years, the number of incoming appeals at the Court of Appeals for Veterans Claims (CAVC) has increased dramatically. In fact, during the first quarter of FY07 the CAVC received over 1,500 new cases—the highest level of incoming cases in CAVC's history. Of the 15 additional FTE requested for the Office of General Counsel, how many will be allocated to assist in handling cases pending before the CAVC?

Response: Dependent upon the Office of General Counsel's (OGC) approved budget and balancing critical hiring needs among all of our offices, OGC expects to apply 11 of the 15 new FTE to our Veterans Court Litigation Group, referred to internally as Professional Staff Group VII (PSG VII).

OGC has closely tracked the significant rise in new cases before the CAVC. PSG VII represents the Secretary before the CAVC. PSG VII experienced a 37 percent increase in workload from 2005 to 2006. We project an additional 57 percent increase from 2006 to 2008. Until Fiscal Year 2006, PSG VII had six teams comprised of attorneys, paralegals, and support staff. In Fiscal Year 2006, OGC created a seventh team within PSG VII to address the rising caseload before the CAVC. The new team includes one GS–15 supervisory attorney, seven attorneys (GS–12/13/14), two legal assistants (GS–5/6/7) and one copy clerk (GS–2/3). Since the Fiscal Year 2006 budget cycle predated the significant rise in caseload before the CAVC, the new team had not been identified as a specific initiative in OGC's Fiscal Year 2006 budg-

et. OGC increased PSG VII's FTE by 13 from November 2005 to January 2007. OGC's request for 15 additional FTE is, in part, designed to increase our budget base to pay for the new PSG VII team established in Fiscal Year 2006 and restore much-needed payroll funds to fill critical vacancies in our other offices.

HEALTH/IT

Question 1. What percentage of returned OEF/OIF servicemembers have undergone either VA-administered or DOD administered mental health screenings? Of that percentage, how many have been diagnosed with post-traumatic stress disorder or other mental health issues?

Response: While VA understands that DOD policy is to screen all OEF/OIF servicemembers upon return from deployment and again 90–180 days post deployment, only DOD has data on the numbers/percentage actually screened.

It is VA policy to screen all OEF/OIF veterans who come to VA for care. As of November 2006, 205,097 (32 percent) of the 631,174 separated OEF/OIF veterans eligible for VA services had sought services at VAMCs and clinics. Of 205,097, 73,175 (35.7 percent) received a provisional diagnosis of a mental disorder, and among the 73,175 group, 33,754 (46.1 percent) were given a provisional diagnosis of PTSD.

It should be noted that a provisional diagnosis of PTSD only indicates that the veteran has responded positively to three of the four items on the screener for PTSD or that there were other indicators suggesting a possible diagnosis. It does not mean that the veteran has been definitively diagnosed with PTSD. Additional evaluation, which may include testing, is generally required to make a diagnosis of PTSD.

Question 2. Your budget request suggest VA Pharmacy Services will increase 30 percent from Fiscal Year 2006 to Fiscal Year 2008. Traditionally, VA has been able to keep its pharmacy cost increases fairly low. Is VA's ability to hold down its pharmacy costs waning or is there another explanation for the substantial growth in this budget line over a 2-year period?

Response: This increase in expenditures is a result of several factors. VA projects a 9.6 percent increase in use of 30-day prescriptions from Fiscal Year 2006 to Fiscal Year 2008 due to a slight increase in enrollment, the aging of the enrollee population, and the increasing importance of prescription drugs in the medical management of diseases. It also reflects the continued increase in the cost of prescription drugs due to inflation and the development of more expensive drugs. While VA's national formulary, pharmacy management practices, and contracting efforts are effective in promoting appropriate use of prescription drugs and containing costs, VA is still impacted by changing medical practice and inflationary increases in prescription drug costs.

VA believes this increase in use of drugs and the use of more expensive drugs will continue. Many chronic care conditions require multiple drug regiments for a patient to achieve a therapeutic goal.

Question 3. Under current Appropriation law, VA's Medical Care budget is broken down into three components: Medical Services, Medical Administration, and Medical Facilities. Health-related Information Technology expenditures are yet another account. Does this structure in any way assist VA in better understanding its budget expenditures? Or, is the three account structure mostly a burden with little benefit? Please explain your answer with some detail.

Response: The three main accounts are: Medical Services, Medical Administration, and Medical Facilities. The multiple accounts do not more accurately reflect VA's medical care expenditures because the accuracy is achieved by charging expenditures to cost centers which are associated with the multiple appropriation accounts. The cost centers are the same ones that existed under the single appropriation structure. The four accounts significantly increase the complexity of financial management at each individual medical facility without improving the accuracy of accounting. The multiple accounts create the false perception that only the Medical Services account is directly related to patient care which is not correct. For example, the salary for physicians and nurses who treat patients are paid from the Medical Services account, the salary for security guards who protect patients and staff are paid from the Medical Administration account, and the cost of utilities to heat and cool the patients are paid from the Medical Facilities account—all are essential to the delivery of high quality health care services to our veterans. The Medical Services account is not the only account directly related to patient care. The benefits of the multiple account structure do not outweigh the benefits of the previous single account structure.

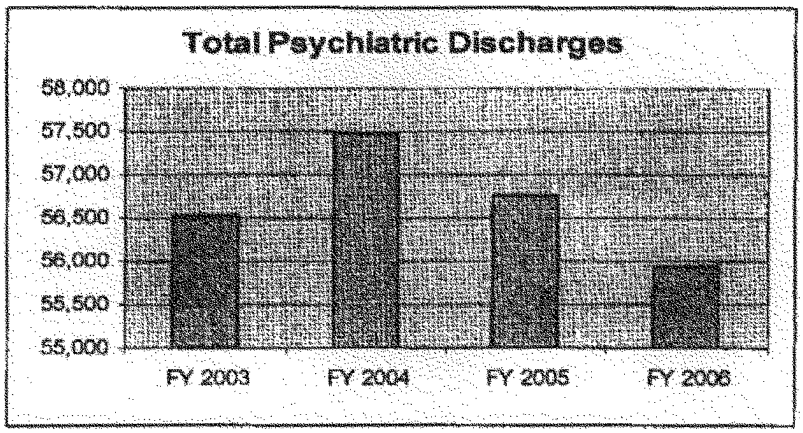
Question 4. Your budget suggests that the total number of veterans in need of mental health care services who will be treated in an inpatient setting will drop by approximately 1,300 veterans and the average daily census for this program will drop by 103 veterans. How much of this drop, if any, is related to reductions in service, bed numbers, and employee levels? How much of this drop, if any, is related to changing treatment patterns (i.e., less long-term stays on psychiatric wards) and new atypical antipsychotics drugs keeping veterans out of inpatient settings? Please provide a detailed explanation including—if known—the average age of inpatient psychiatric patients as well as the average length of stay controlled for age.

Response: Similar to all other clinical settings, psychiatric care in VHA has evolved over the past decades from a predominantly inpatient based system to one that is predominantly clinic based. Since Fiscal Year 2002, the number of average operating beds for all VHA psychiatric services has dropped steadily from 7,565 to 7,250, while the occupancy rate has similarly declined from 72 percent to 60 percent through November, Fiscal Year 2007. These beds include general psychiatry, substance abuse, and psychosocial residential rehabilitation treatment program (PRRTP) beds, but not domiciliary or nursing home beds.

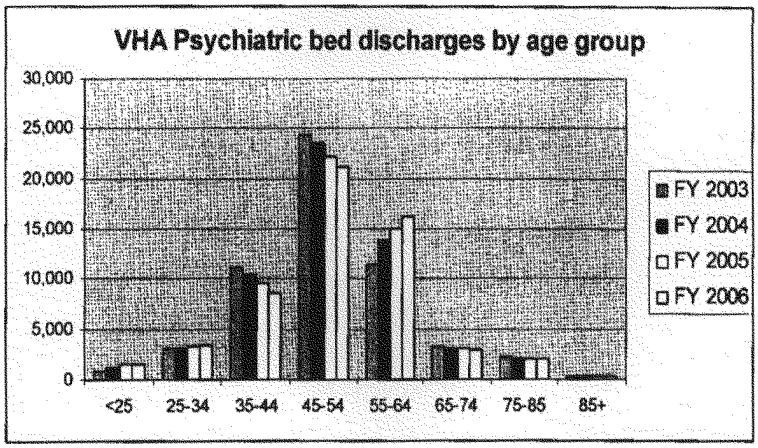
Although there is some drop in beds over this time, there is also a drop in occupancy rates. Thus, it would appear that the demand for available beds is diminishing. The occupancy rates demonstrate that inpatient care beds are not filled, and that there is capacity in the system as a whole to admit patients in need of hospitalization.

From another perspective, the number of veterans discharged from VHA psychiatric beds has varied over recent years. It was 56,513 in Fiscal Year 2003; 57,485 in Fiscal Year 2004; 56,756 in Fiscal Year 2005; and 55,937 in Fiscal Year 2006. While there have been overall decreases in the number of hospitalizations since Fiscal Year 2004, the trend since 2003 can best be interpreted by suggesting that the use of inpatient services fluctuates from year to year. As noted already, however, the current occupancy rates demonstrate that the system can accommodate the needs in higher utilization years.

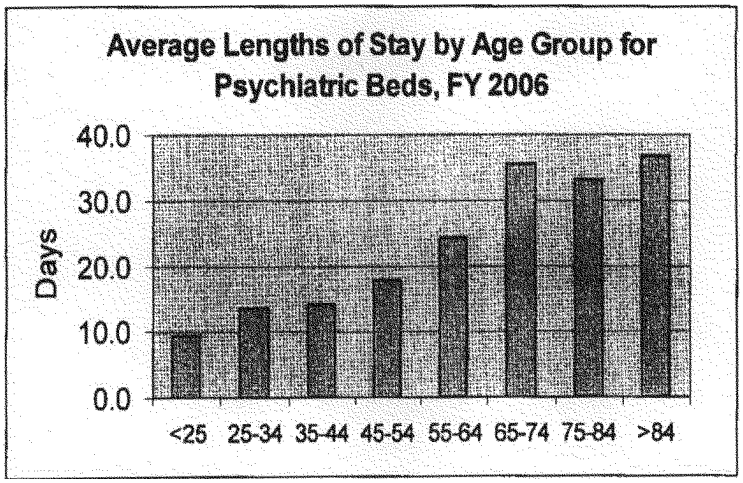
Thus, looking at the past 4 years, it is not clear if the if use of psychiatric inpatient services has leveled off, or whether there is still evidence of a persisting but slowed rate of decline. The presence of substantial numbers of beds that are not occupied on any day argues strongly against the availability of services, the number of beds, or the number of employees as being the reason for any decreases in admissions and discharges. Instead, any decreases in use of inpatient psychiatric services could be attributed to increases in services such as mental health intensive case management, psychosocial rehabilitation, homeless programs, and substance abuse treatment services.



While the average age of all veterans hospitalized in VHA psychiatric settings remains in the mid 50s, there is a shift since Fiscal Year 2003 from 43 percent in the 45–54 age range to 38 percent, while the 55–64 age group increased from 20 percent to 29 percent. The number of veterans over age 65 discharged from psychiatric bed sections actually decreased from 10.1 percent to 9.4 percent during that period. The under 35-year-old age groups increased marginally from 6.7 percent to 8.8 percent.



The average lengths of stay by age for all psychiatric beds reveals that veterans stay for shorter periods of time than older veterans.



Question 5. I noticed that the budget for the CHAMPVA program is growing at incredible rates. By my count, it has gone up several hundred percent since 2001. What is the primary driver of these large increases?

Response: The civilian health and medical program VA (CHAMPVA) provides payment for medical services for the dependents of veterans rated permanently and totally disabled, or dependents of veterans who succumb to VA rated service connected conditions. CHAMPVA is comprised primarily of dependents of World War II, Korean, and Vietnam era veterans.

The two major drivers causing upward cost pressures include unique users and medical cost per unique user.

Unique Users—Since 2001 the number of CHAMPVA enrollees increased by 158 percent; concurrently, the number of enrollees using benefits increased by 203 percent. The majority of this enrollment growth occurred with the enactment of Public Law 107–14, which extended CHAMPVA benefits effective October 1, 2001, to beneficiaries aged 65 years and greater.

Medical Cost per Unique User—This cost driver includes usage rates, acuity levels, and medical consumer price index (CPI).

• Usage rates, or the number of enrollees with at least one paid claim per year, increased 203 percent since 2001. The percentage of beneficiaries using program

benefits in 2001 was approximately 58 percent; this participation rate increased to 68 percent in 2006.

• The acuity level, based upon the number of annual claims paid per user, increased from 21.5 claims paid per year in 2001 to 30.2 claims paid per year in 2006, an increase of 40 percent. The annual cost per user was $2,350 in 2001 and $3,285 in 2006, an overall increase of 39.8 percent.

• The annual increase in the cost of medical services, or the medical CPI, increased 26 percent from 2002 to 2006, an annual rate of change of about 5.0 percent.

Question 6. I am glad to see that the Department is committed to completion of construction projects that are already underway, all of which were authorized by Congress last year as part of a $3 billion medical construction bill. These are not small price tags, and the Committee is committed to ensuring that VA's capital assets align with care needs for optimal access for veterans and efficiency for taxpayers.

Question 6(a). What is VA doing to control its construction cost? Are there further sharing and lease opportunities that VA could use to leverage its resources?

Response: The Department, along with other government agencies and private sector businesses and individuals, is experiencing a significant growth in the cost of construction as a result of the booming construction economy worldwide. The significant demand for contractors, labor and building materials has produced significant increases in pricing. This has been further exacerbated by higher petroleum prices on both petroleum based building products and fuel as well as construction related impacts of the hurricanes of 2004 and 2005 including Katrina.

In order to position the Department to best deal with this situation, VA has taken several steps. These include developing a more detailed market analysis of individual geographic location to ensure that the best available information is used when establishing the escalation rates that will be used in the cost estimate. These in consideration to market timing to the extent practical in order to bid the project at a time when there is the best opportunity to have the greatest competition by the contracting community. VA has also began to employ more extensive preplanning before a project is placed in the budget to be sure that all issues relating to scope, building systems and constructability have been identified and their costs recognized.

Question 6(b). Are there further sharing and lease opportunities that VA could use to leverage its resources?

Response: On December 4, 2006, the Secretary approved a decision document launching a Site Review Initiative. The intent of this initiative is to market and decrease the amount of underused VA property while reinvesting the proceeds into programs and activities at the Secretary's discretion. The Assistant Secretary for Management will provide the Secretary with a site assessment by April 2007.

Question 7. Please detail the status of VA's IT organizational restructuring. Are funds for the restructuring fully budgeted for in the Fiscal Year 2008 request?

Response: On October 19, 2005, the Secretary approved the concept of a Federated IT System for the VA and charged the Assistant Secretary for Information and Technology with the development of a Federated Model and a follow-on implementation plan. The Federated Model is a framework that defines the VA Federated IT System by separating IT into two domains—an Operations and Maintenance Domain that is the responsibility of the Assistant Secretary for Information and Technology (VA's Chief Information Officer) and an Application Development Domain, that is the responsibility of the administrations and staff offices. The Federated Model was approved by the Secretary on March 22, 2006.

VA contracted with IBM to recommend the best business practices and develop processes to manage VA IT capabilities and resources. On October 1, 2006 over 4,200 employees who worked in IT operations and maintenance across VA, nationwide, were centralized under the Office of the Assistant Secretary for Information and Technology.

On October 31, 2006, the Secretary approved the transition of VA IT management system from the Federated IT System model to a single IT leadership authority under the Assistant Secretary for Information and Technology. With this approval, all VA IT employees who worked in the IT Applications Development Domain, approximately 1,200 employees nationwide, were detailed to the Office of the Assistant Secretary for Information and Technology in December 2006.

On February 27, 2007, the Secretary approved a modification to VA IT management system to implement a process-based organization structure for the Office of Information and Technology. This restructuring is an important step for driving IT standardization, compatibility, interoperability, and fiscal management disciplines across VA in support of veterans' programs and services.

The resulting construct of this more than 2 year effort is a centralization of VA IT personnel and financial resources and physical assets including all IT equipment, all VA data processing centers nationwide. Any requirements necessary for this restructuring are included in the Fiscal Year 2008 budget request.

CEMETERIES

Question 1. What is the status of VA's efforts to fund the needed cemetery repairs identified in 2002 in the *Study on Improvements to Veterans Cemeteries: Volume 2, The National Shrine Commitment*. Please incorporate in your answer the expected outlay of Nation Shrine Commitment dollars as part of VA's FY07 appropriations, and expected outlay under VA's FY08 request.

Response: We are making steady progress completing the repairs needed to ensure that each national cemetery is maintained as a national shrine.

The Millennium Act Report to Congress (Volume 2, National Shrine Commitment), issued in August 2002, provides a comprehensive assessment of the condition of VA's national cemeteries. This information is used in NCAs planning process to assist in prioritizing national shrine projects over a multi-year period.

The report identified the need for 928 repair projects at an estimated cost of $280 million to ensure a dignified and respectful setting appropriate for each national cemetery. NCA is using the information and data provided in the report to plan and accomplish the repairs needed at each cemetery. Through Fiscal Year 2006, NCA completed work on 269 projects, and initiated work on additional projects, with an estimated cost of $99 million.

Repairs to address repair/maintenance needs are addressed in a variety of ways. Gravesite renovation projects to raise, realign and clean headstones and markers and to repair sunken graves are addressed through NCA's operations and maintenance (O/M) account. Infrastructure improvements to buildings, roads, irrigation systems, and historic structures are addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff is used to complete some repairs.

In Fiscal Year 2007, NCA plans to spend $16.6 million specifically for national shrine projects—$9.1 million from O/M and $7.5 million from minor construction. The 2008 budget includes $11.1 million for national shrine projects—$9.1 million in the O/M account and $2 million in the minor construction request.

In addition to specific national shrine projects, a commitment to enhancing the appearance of the national cemeteries underlies all NCA activities. Over 30 percent of NCA's operating budget is used for routine tasks such as mowing, trimming, and other maintenance work. These functions are equally critical to providing enduring memorials to those we serve.

Our progress in improving the appearance of our national cemeteries is evidenced in our performance results. In Fiscal Year 2006, 97 percent of respondents rated the appearance of our national cemeteries as excellent. Our target for Fiscal Year 2007 and 2008 is 99 percent.

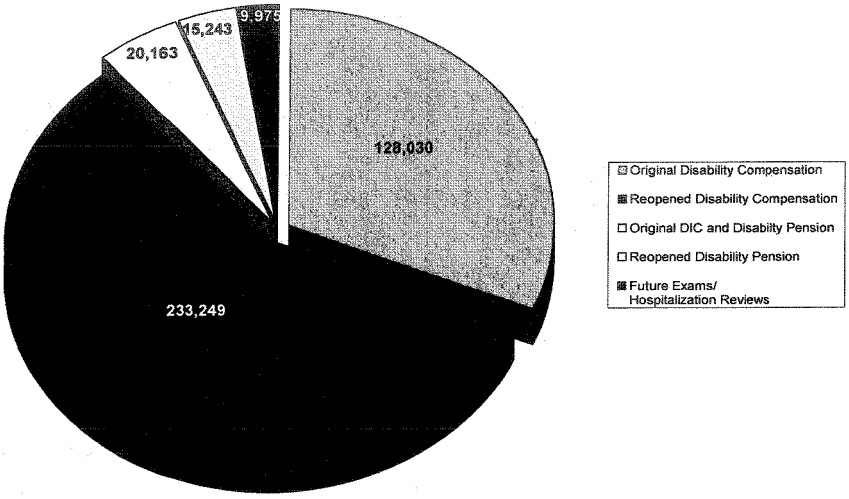
NCA has also established an organizational assessment and improvement (OAI) program to ensure regular and consistent assessment of performance against established standards. Each national cemetery will be evaluated through site visits conducted on a cyclical basis. A total of 47 national cemeteries have been reviewed under OAI since the program's inception in 2004. In addition, NCA has developed additional performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data was collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Funds available in Fiscal Year 2007 and included in the 2008 budget request will allow us to continue work toward improving the appearance of our national cemeteries. This is a multi-year effort, and VA is committed to ensuring that a dignified and respectful setting for each national cemetery is achieved. Future budget requests tied specifically to the shrine commitment will be prioritized within the context of Departmental priorities. For example, critical gravesite expansion projects require our immediate focus in order to keep existing cemeteries open and to ensure continued service to our nation's veterans and their families.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JIM WEBB TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Provide the current inventory of pending rating-related claims:

Response: VBA defines the claims processing workload as the number of liability claims requiring a rating decision. The chart below shows rating-related workload by type of claim.* As of April 7, 2007, 406,660 claims were pending.



*Rating-related workload by type of claim:
Original Disability Compensation—128,030
Reopened Disability Compensation—233,249
Original DIC and Disability Pension—20,163
Reopened Disability Pension—15,243
Future Exams/Hospitalization Reviews—9,975

Question 2. Utilization of Benefits. I would be curious if you could get us something just in terms of utilization of the VA system, writ large. What are we going to estimate in terms of how many people are going to take advantage of one or another benefit in the VA system, whether it is home loans or compensation, pension, education benefits?

Response. VA does not have access to date that would allow us to compile this information for the entire veteran population. We are working with DOD to obtain inforamtion that will allow us to compile data on benefits usage for veterans of the Global War on Terrorism (GWOT). The Information we currently have available is provided in the table below. We are continuing to work to expand and refinethis data. Because many GWOT veterans had earlier periods of service, the benefits activity identified in the table could have occurred *either prior to or subsequent to their GWOT deployment (or both).*

Total Living GWOT Population—686,306

(Based on DOD separations through November 2006)

	GWOT Veterans (percent)
Veterans with disability claims decisions—148,891 (data through 12/06	21.7
Veterans who accessed the VR&E program—12,168 (data through 12/06)	1.7
Veterans awarded TSGLI benefits—1,569 (data through 01/24/07)	0.2
Veterans who have obtained a VA home loan—154,377 (data through 01/31/07)	22.5

Note: Percentages reflect unique veterans within that business line only.

We can provide the estimated number of servicemembers, veterans,a nd survivors that will receive or use VA benefits in FY 2007 and FY 2008.

Beneficiaries	2007 Estimate	2008 Estimate
Veterans Receiving Disability Compensation	2.7 million	2.9 million
Survivors Receiving DIC	330,000	340,000
Veterans and Survivors Receiving Receiving Pension	523,000	512,000
Veterans who will access the VR&E program	92,000	94,000
Veterans who will obtain a VA Home Loan	180,000	180,000
Serviemembers, Veterans, and Survivors Covered by VA Life Insurance	7 million	6.9 million

Chairman AKAKA. Thank you very much, Mr. Secretary.

At this time the Chairman calls for a very brief recess that will be at least 5 minutes, maybe a little bit more.

Thank you.

[Recess.]

Chairman AKAKA. The Committee will come to order.

Mr. Secretary, before I start my questions, I want to commend you on your final remarks about extending yourself to the families of veterans and also your outreach program for the severely injured and for your meeting with the combatant commanders. I think this will be of great benefit to our veterans.

Mr. Secretary, I note that it is certainly true that VA has received significant budget increases during this Administration's tenure, as you testified and as others have mentioned. It is also true that these increases are a result of both Administration proposals and actions by the Congress, and my simple question to you is: Do you agree with that statement?

Secretary NICHOLSON. I think that both the President and the Congress have been very supportive of the VA, yes, sir.

Chairman AKAKA. Well, thank you. I want you to know that this Committee works well together, in a bipartisan manner, to help our veterans.

Mr. Secretary, I would like to expand on what I touched on in my opening statement, regarding the actual level of funding requested for health care. As I said, when you take into account the $2 billion in what the budget calls "health care industry trends"—increases due to inflation and other factors—there does not seem to be any funding left for the top priorities. I am talking about mental health improvements and ensuring that the needs of returning war veterans are met.

My question to you is: How can VA both cover inflation and other costs and still make the improvements that we all know are needed?

Secretary NICHOLSON. Thank you, Mr. Chairman.

Mr. Chairman, we are requesting a 10.3 percent increase for health care in the budget, 2007 to 2008, and believe that with the pay increase that would be anticipated in that and inflation, there would still be above that a 3.6 percent increase in the Health Administration. That is after adjusting for inflation, after adjusting for the pay increase.

Chairman AKAKA. Dr. Kussman, I note that inpatient care in various settings is facing a big cut in this budget. You expect to have fewer patients in rehab and psychiatric units as well as in residential facilities. I do not believe that these cuts are being driven by good medical practice. I understand clearly that outpatient care is the best approach in some cases, but we must, however, own up to the fact that this war is resulting in some young vet-

erans who will need substantial inpatient treatment. Just last week, a family wrote to me about their son who died in a VA facility from a drug overdose after spending only 2 weeks in an inpatient unit.

Can you please explain why VA should be losing beds now?

Secretary NICHOLSON. Well, you touched on it, Mr. Chairman. The paradigm for VA health care in general is for more outpatient care. That is, as some of the statistics were cited, a great frequency of visits to a facility. But we also are using far more of the technology of our times—telemedicine, telehealth, we are doing teletherapy. So there is an increasing usage of those technology.

But I could tell you, Mr. Chairman, that we have the capacity and that no veteran who is in need of acute mental health care is turned away. They are admitted.

Chairman AKAKA. Mr. Secretary, I would like to ask for specifics on the enrollment fee proposal this year. In my statement, I mentioned the new out-of-pocket costs for working families. In creating this year's version of the enrollment fee, what attention was given to families with dependents, families with two veteran wage earners, and other similar situations?

Secretary NICHOLSON. There was a lot of discussion given to these policy proposals which have been proposed in some form for six years. I have testified now for the third time on this concept, and I will tell you that I support it. I support it on a practical basis, and I support it on an equitable basis.

What we are talking about here are veterans who have no service-connected disability, no diminution as a result of their service, which is the whole theory behind the VA. If someone has suffered physically or mentally as a result of their service, they are to be compensated by a grateful country. These people have not had that experience, and they have income.

We have looked at and reflected on the experiences of the previous years, where you all here in the Congress have not been very supportive of this. And so we discussed a progressive system where people making less than $50,000 would not be asked to pay this modest enrollment fee. Again, keep in mind, if you would, sir, and Members of the Committee, no one with any service-connected disability pays this under this proposal.

Second, there is an equity argument because if you are a person who served in the military for 30 years or 35 years and take off the uniform and go into the TRICARE health care system, you pay an enrollment fee, and you pay a copay. We can debate that. I think it is fair to say they are modest. But they are more than what is being asked here.

In an environment of somewhat finite resources, if you want to assume that the resources are finite, then we have to make priorities, which we do, and try to direct resources toward those who need us the most. That is the policy behind this.

Chairman AKAKA. Let me ask in particular, if there were two veterans who were married to each other with a combined income of $50,000 a year would each be assessed the fee?

Secretary NICHOLSON. Yes, they would, Mr. Chairman. If they were both patients in our system, yes.

Chairman AKAKA. Thank you.

Now, I will call on our Ranking Member for his questions.

Senator CRAIG. Thank you very much, Mr. Chairman.

Mr. Secretary, I apologize for having to step out to another hearing to give testimony, and I do appreciate your presence and that of your staff and associates here today.

Your budget talks about focusing aggressively on reducing waiting times for current patients, specifically targeting those patients who are waiting the longest for care. Certainly, it makes sense to all of us that that happens, and we have worked on that progressively over time.

Can you talk a little about who is now waiting the longest for care? Is it a function of individual facilities that struggle to deliver timely care? Or is it certain specific services, such as neurology or orthopedics? In other words, what are the drivers in the time here? What are the drivers in the waiting time involved?

Secretary NICHOLSON. Thank you, Senator. Let me again repeat the good news part of this, which I think is significant, in that 95 percent of all people who want an appointment of any kind get it within 30 days, and 96 percent get an appointment within 60 days.

There are some of these specialties that do have to wait longer, among which are dermatology and ophthalmology. The primary reasons for that are our resources in those specialties and our ability to be able to hire and retain doctors in the numbers that we need.

We have been assisted by you in recent legislation where we can incentivize them into the VA, and we are doing that. That is helping. But that is the main part of that.

Senator CRAIG. And all of these categories are non-emergency type settings. Is that correct?

Secretary NICHOLSON. Yes, sir. There is no veteran who is in need of, as they say, emergent or emergency care that does not get it immediately. If we cannot provide it, he or she is taken to a local facility.

Senator CRAIG. It was interesting that you would mention dermatology. My wife will probably crucify me for bringing her into this. She in a routine way scheduled a meeting with her dermatologist about a month ago, and it occurred last week. In the civilian landscape, non-emergency type routine access to health care oftentimes takes that long, depending on where you are in the delivery system and all of that kind of thing. I find it fascinating that you would mention that.

Ten years ago, Mr. Secretary, every Member of this Committee signed a budget letter stating that VA entitlement spending did not show spiraling growth patterns. We concluded that VA entitlement programs were—and this is the quote from the letter—"not among the chief factors in looming Federal deficits." VA entitlement spending has since jumped by nearly 100 percent. As our bipartisan letter then put it, "I am worried that we have entered into a pattern of unsustained growth."

What are the causes of the growth in VA entitlement spending? And is this growth expected to continue at its present rate?

Secretary NICHOLSON. The causes, Senator Craig, are multiple. One of those is very active, aggressive outreach by the VA, and it takes several forms. We have now over 140 VA benefit counselors

embedded in military units throughout the world who are there to counsel and educate and make aware those people who have a separation from the service coming up. And we have people at all the major points of embarkation, people redeploying back from the combat zone.

We have traveling groups of outreach counselors who go out and set up displays at Veterans Service Organization events. Two weeks ago, I was in San Antonio for the dedication of the Center for the Intrepid, and we had a major outreach, a static display with staff for the many veterans there to become more aware of what they are entitled to. And they are entitled to substantial benefits, depending, of course, on their situation.

Then there is the corresponding fact that more and more of them are coming in, as I said, in absolute numbers. In 2006, we had 806,000 individuals come in and make a claim.

The other thing that is happening is the demographics of veterans—some of us are older. Fifty percent of our veterans are over 60, 45 percent of our veterans are over 65, and they begin to have more ailments from their experiences or arthritis and different things. So that is an individual claim, each of those, individual clinic visits, individual adjudications. And the underlying philosophy that is imparted to the VA in this system is to grant a claim if you can and deny only if you must.

And so the system, I think, is quite beneficial and people are coming in in ever increasing numbers.

Senator CRAIG. Thank you.

Thank you, Mr. Chairman. My time is up.

Chairman AKAKA. Thank you very much, Senator Craig.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman.

I wanted to follow up on the Chairman's line of questioning on the need for inpatient mental health care, because I, too, was really disconcerted to see the budget request projecting fewer veterans needing inpatient mental health care. I understand the philosophy of trying to do more and more outpatient, reach more people that way, but it just seems to me, when one in three Iraq war veterans are estimated now to be seeking mental health care, many of our servicemembers are now on their second or third, some even fourth deployments. We are hearing about the intensity on the ground and what our men and women are facing and the consequences when they return home, and the President now sending up to 48,000 more troops. It just seems to me that we are going to need more inpatient psychiatric services, not less. And I want to hear your rationale on that.

But, you know, you made a comment that struck me because you said no veteran has been denied inpatient health care, mental health care, yet we heard about a highly publicized case of an Iraq war veteran with two Purple Hearts named Jonathan Schulze, who tragically took his own life, and the press reports were that he had asked for help from the VA twice and was told he was 26th on the waiting list. We have heard about cases in Minnesota as well as—or he was from Minnesota, but also a case in Illinois and in Iowa.

It just seems to me when you have that many red flags going, you cannot just arbitrarily say no one is being denied care. And,

you know, I think we have to say there are red flags out there. We need to find out what is going on.

So I would ask you two questions: We are hearing about these cases that say veterans are being denied care when they ask for it. And, second, how can you predict a lower demand for inpatient psychiatric services in your budget when we know there are going to be increasing consequences as the years progress?

Secretary NICHOLSON. Thank you, Senator Murray. Those are several important questions, and I like having the opportunity to respond.

First, our budget for psychiatric inpatient care is actually up. I am looking at it. We are asking for $1.6 billion——

Senator MURRAY. Right. Your budget request has increased, but you are projecting that fewer veterans will need inpatient health care.

Secretary NICHOLSON. Well, let me give you the capacity figures. You know, what we have anticipated our needs to be is what we should request from you the money to fill.

In our capacity for mental health, we are currently being utilized at 70 percent, and for polytraumatic care in our polytrauma centers, it is 80 percent. So we have, in the case of mental health in general, a 30 percent capacity available; in the case of polytraumatic capacity, we have 20 percent available.

Let me also address—you raised the point——

Senator MURRAY. Are you talking nationwide 20 percent available? Because if those facilities are not where our veterans are, it does not make any difference. They are not going to travel 5,000 miles to get inpatient care.

Secretary NICHOLSON. We have 154 inpatient facilities around the country and almost 1,000 other points of access for veterans to come in to be screened, to be referred.

I want to address the other point that you raised to the extent that I can, and I am limited by the privacy regulations because the family has not given us a waiver to discuss this. But the case that you mentioned from Minnesota, which comes up often, that veteran was seen by our facilities in Minnesota 46 times. That is about all I can say.

Senator MURRAY. OK. I understand extenuating circumstances in all cases, but it is not an isolated case. We are hearing about cases elsewhere.

But my question to you is: Do you really think that we are going to see fewer veterans needing access to inpatient mental health care?

Secretary NICHOLSON. Well, we are projecting that we are going to see somewhat fewer of those cases in this time frame.

Senator MURRAY. Well, my time is up, and I want to ask another quick question. But, Mr. Chairman, I think we have to be careful not just to project numbers on the hopes of keeping the budget down, but really looking at what we are going to need to pay for because of inpatient care. And as you have stated and as I referred to, we do have, you know, many veterans who are in their second, third, possibly fourth tour. We have 48,000 additional troops being sent, and we are seeing a third of our veterans seeking mental

health care. So I hope we look very carefully at those numbers as we put our budget together.

But let me ask one other question really quickly in my time. I wanted to ask you about shorter hours at our urgent care in Spokane—I am going to submit that for the record—because we have a serious concern about that facility closing at 4:30 in the afternoon. We have one if not more cases of veterans who have died because they have shown up shortly after the facility closed, and there is a huge problem with how veterans perceive their care if they do not go to the VA facility not being paid for. That is an issue I want to address with you on another occasion.

But I also wanted to ask you about these increased user fees and copays because, as you know, I oppose that. I believe that anybody that we ask to serve us should not be given an additional cost to get their health care. That is not what they were told. But I am disturbed that in the proposal this year that you asked to put that money from fees, should it ever be collected, back into the general budget rather than into the VA health care. And it seems to me what that simply is saying to our veterans is we are asking you to balance the Federal budget now. And I find that even worse than the suggestion that they should pay copays, and I wanted to ask you why you have changed that policy and why you are suggesting that in this budget.

Secretary NICHOLSON. Well, the reason for that, Senator Murray, is that if you will recall other discussions that we have had about this, the revenue that was assumed in the budget was used to apply for the needs on the application side of the budget. So having an experience where it has not been approved and then having a gap, instead of doing that, we did not assume it. This budget, if you approve it without those measures, will still have the money that we need.

Senator MURRAY. So basically we can balance the budget if we charge our veterans fees. I just find that incom——

Secretary NICHOLSON. No, no. I am not being artful in trying to explain it. If you deny it, there will be no gap in this budget where you have to find it somewhere else.

Senator MURRAY. For the VA.

Secretary NICHOLSON. Right.

Senator MURRAY. I know my time is up, Mr. Chairman. Thank you.

Chairman AKAKA. Thank you very much, Senator Murray. Let me tell you that we have a second round of questions for this panel, and then we will have our next panel.

At this time, Senator Jim Webb.

Senator WEBB. Thank you, Mr. Chairman. May I ask a procedural request? Our colleague, Senator Tester, had to leave in order to preside, and he asked that I ask a question on his behalf. I would request that the clock be reset once I have asked the question on his behalf.

[Laughter.]

Chairman AKAKA. Senator Webb, granted.

Senator WEBB. Thank you, Mr. Chairman.

Mr. Secretary, the question that Senator Tester wanted to get an answer to regards the growth in the claims and the indication that

it has now gone from 500,000 to over 800,000. And he had had a number of constituent contacts that indicated that a lot of the claims that are going forward had been kicked back for more information and this sort of thing. And so his question was, "What percentage of this claim backlog involves recycled or incomplete claims? And if you do not have that today, could we please have that?"

Secretary NICHOLSON. Thank you, Senator Webb. I do not think we have that, and we will get that. I can ask Admiral Cooper, the Under Secretary for Benefits, if he would like to expand.

Admiral COOPER. Yes, sir. We have a very specific process established by law as to how to process a claim, and no claims are sent back to the individual. We do go to them and tell them specifically what we require in order to properly adjudicate their claims. We also state precisely what VA will do to properly obtain the information. Once we get all the information in and make the decision, then they will occasionally appeal that decision. The appeal process is a separate process. Appeals are not counted as part of the approximately 400,000 claims that we have pending today.

Senator WEBB. So when you say 400,000, you are talking all of those are initial claims?

Admiral COOPER. All of those are initial, but the term "initial" requires explanation. They are either original, that is, the person has come in for the first time, or they are reopened, which means that the person having had a claim adjudicated previously, now comes in because his or her condition has deteriorated or the veteran claims service connection for another condition that has not been claimed before.

Senator WEBB. Or new information——

Admiral COOPER. Or they have new information——

Senator WEBB. Could you get us some sort of a breakdown so we could understand that?

Admiral COOPER. Of course.

Senator WEBB. Thank you.

Mr. Chairman, if we could now reset the clock, I will do my best to ask a few on my own time.

I was struck by a number here, a percentage here—I am just trying to get my data points as I join the Committee—that says out of the 198,000 military separations in 2006, trends show that 35 percent will file a claim over the course of their lifetime. I am assuming that means some sort of a compensation claim. What I am curious about is what percentage are we estimating a vet is going to use a benefit, because I recall even from the Vietnam GI bill alone it was about a two-thirds participation rate.

Secretary NICHOLSON. I will review the top line, Senator, and then if Admiral Cooper wants to come in. If you think of the veteran population as a whole in the country today, it is about a little over 24 million: 7.8 million of them are enrolled in our health care system; 5.6 million present themselves every year for medical treatment. But that is on the average of 10.1 times, which means that we see over 1 million people a week in the health care system. On the claims side, about 35 percent of those that we——

Senator WEBB. So we are defining a claim as a claim for compensation?

Secretary NICHOLSON. Yes, sir.

Senator WEBB. Purely. OK. I just wanted to make that clear. I would be curious if you could get us something just in terms of the utilization of the VA system, writ large. What are we going to estimate in terms of how many people are going to take advantage of one or another benefit in the VA system, whether it is home loans or compensation, pension, educational benefits? I would venture that number is well in excess of——

Admiral COOPER. I do not have that information now, but let me get back to you in writing.

Senator WEBB. OK. Great. Thank you.

As I mentioned in my opening statement, I am very desirous of ensuring that these people who have been serving since 9/11 get an educational benefit that is worthy of the service that they have given. I think we are all aware that the Montgomery GI Bill, which is a good GI bill, a good peacetime GI bill, has its limitations. I am wondering if you would agree that the post-9/11 veterans should receive a better educational reward than that which they are now getting.

Secretary NICHOLSON. Well, you recognize, Senator, that I am here as a representative of the Administration, and what you are talking about is a major policy implication with significant cost ramifications which have not been scored.

We will, if you ask, analyze that and give you the benefit of our judgment in concert with the Administration, whom we represent and, as you know, I think, is very supportive of veterans and appreciates the importance of education and what the GI bill has meant to veterans and to our country, which I certainly support as well.

Senator WEBB. On a personal level, I assume that I am hearing that on a personal level you probably would agree with that, or are you comfortable in saying——

Secretary NICHOLSON. I have to qualify my answer, but I will tell you, coming from a family that had to get through college—all seven of our kids in my family went to college by hook and by crook, and I was lucky I got to go to the Military Academy. And knowing what education means in this country, I have some concern about our Reserve and National Guard and whether they are being equitably benefited because of their service, their active-duty service now in this war, I think that is a legitimate thing to be looking at.

Senator WEBB. Did the Administration support the legislation that allowed attorney representation in VA claims? I was not here when——

Secretary NICHOLSON. It did not.

Senator WEBB. It did not?

Secretary NICHOLSON. No, sir.

Senator WEBB. Do you have any indication of how this new concept has affected the increase or decrease in caseload?

Secretary NICHOLSON. Well, no. The answer is no, but we are working on that. It is now the law, and we are charged with implementing it and coming up with the standards for the attorneys, the system, to look out for the interests of the veterans in this case to see that they are well and fairly represented and that the com-

pensation is a fair system. It is not yet in effect, but we are looking at it.

I think part of your question, if I hear it right, is what effect is this going to have on waiting times on this system.

Senator WEBB. Yes.

Secretary NICHOLSON. And I will tell you that I think it is going to have an effect of stretching them out. I mean, I cannot help reflecting I grew up in this little town of 99 people that had one country lawyer that used to play pinochle every afternoon at the one tavern, and then a young lawyer moved in, and then they were both busy.

[Laughter.]

Secretary NICHOLSON. So this is going to have an effect on waiting times, I think there is no question.

Senator WEBB. I would agree with your concern in that area, quite frankly. I have watched the quality of the national service officers over the years, people who have become specialists in Title 38. And it is worrisome if we were to go to a system where a veteran would feel compelled to have to obtain an attorney rather than the free services that have been available, unless that attorney were willing to do it on a pro bono basis, as I have on many occasions, by the way. That is something that I look forward to look at, and I hope there is some kind of a tracking system established where we might get into the timing and those sorts of things and be able to evaluate.

Thank you, Mr. Chairman. My time is up.

Chairman AKAKA. Thank you very much, Senator Webb. We will begin a second round here.

Admiral Cooper, in your personal or professional view, and without regard to the present situation, how long should a veteran or dependent have to wait to have their claim decided?

Admiral COOPER. The goal that we have—and I honestly believe we can get there—is 145 days, predicated on all the laws that are now in place. As you know, the Veterans Claims Assistance Act of 2000 did extend processing time by establishing many specific things that VA is required to do, all for the benefit of the veteran, all for the right reason. But that did extend the process.

As I look at it and try to analyze how we can best reduce the time to the shortest time possible, I find that 145 days—perhaps 140 days eventually—that is probably, realistically, the best we can achieve on average. We will be able to do some claims, very fast assuming we get all the information immediately. But, on average, I think 145 days is about the best we can do.

Secretary NICHOLSON. Mr. Chairman, could I just add an important footnote to that.

Chairman AKAKA. Mr. Secretary.

Secretary NICHOLSON. For clarity, a claim, when it is finally decided, is paid from the time it was initiated. So during that pendency period, if it is given, it is given retroactive back to the time it was filed.

Chairman AKAKA. Thank you for that explanation.

Dr. Kussman, in your personal or professional opinion, should someone seeking a primary care appointment have to wait 30 days to get an appointment? Or in your answer, please give me exam-

ples of other health care systems that use such an extended period for a primary care appointment.

Dr. KUSSMAN. Thank you, Mr. Chairman. As was already mentioned, anybody who has an urgent or emergent issue can be seen right away by walking into one of our clinics or one of our emergency rooms. So if anybody really needs to be seen right away—the issue of the 30 days is for stable, chronic, longitudinal care for the patient that we have been seeing regularly in our clinics.

Chairman AKAKA. Thank you.

Mr. Secretary, I notice that VA's estimated number of OEF and OIF veterans that will come into the system next year is relatively incremental at around 54,000. We know that in the past, VA has underestimated the number of new veterans seeking VA health care. We also know that some conditions such as PTSD can take some time to manifest themselves in these young servicemembers, and that in these current conflicts, the average servicemember will serve more tours than in the past.

Can you please explain the projection that VA will see such a low number of OEF and OIF veterans next year?

Secretary NICHOLSON. Well, Mr. Chairman, we use a very sophisticated model. The model, as you will recall—I know you do—for the 2005 budget year did not hit it because it was based on 2003 actual data, and it did not incorporate the effects of the war into it.

Since that time, that model in the overall patient demand that we have is almost uncanny in its accuracy—less than half of 1 percent off. So we use that. We use it for 85 percent of our predictive capacity. It does not predict certain things like long-term care, dental, and CHAMPA. So we have to apply some judgment into that. But we are quite confident in that estimate that we have for 2008, which is 263,000. And the funding for it, as you will note, we have asked for nearly double that of 2006.

Chairman AKAKA. Thank you very much, Mr. Secretary. My time has expired.

Senator Craig?

Senator CRAIG. Mr. Chairman, I will be brief. We have another panel, and I would like to hear from them before I have to rush out around the noon hour.

There are questions I will submit for the record for the Secretary and his colleagues to answer.

I would only make this observation, Mr. Secretary. Last year, the VA stated that the training of veterans service officers, that once trained by the VA, could help expedite claims. And while you are an attorney and I am not, I cannot imagine that well-trained attorneys in the law could not help expedite claims also. Or is there something about the degree itself that deters them from expediting——

[Laughter.]

Senator CRAIG [continuing].—while VSOs trained by VA can, in fact, expedite claims processes? Now, you must defend your fellow attorneys. I understand that.

Secretary NICHOLSON. I am a recovering attorney, Senator.

[Laughter.]

Senator CRAIG. I see.

Secretary NICHOLSON. But I would tend to repeat my story of Struble, Iowa, and rest my case. The veterans service officers that work on these cases, they are really doing it—they have no financial interest in it. They do not have a clock that is running. It is not dependent on their livelihood. I think they have a more detached view, but in most cases a very competent and committed view. And attorneys—I mean, attorneys are trained to be thorough. If they are not thorough, because they are held to a higher standard, could be held to be negligent, so they do not tend to leave many stones unturned, or they are not too much on an expedition. And I think common sense for me suggests that it will just take longer.

Senator CRAIG. Well, I thank you for that. I visited with the judges down at the court. Thoroughness is part of a problem in why claims are rejected at that level, and thoroughness is something that is important to carry the process through. That is why I felt that the policy of the Civil War era should be put to bed once and for all on behalf of our veterans.

Having said that, Mr. Chairman, I thank you all of you for being here today and look forward to working with you in the coming year.

Chairman AKAKA. Thank you very much, Senator Craig, for your remarks.

Mr. Secretary, before we switch panels, I want to let you know that we will be sending post-hearing questions over to you beginning this afternoon, and others may follow in the next few days. And questions from Members will be submitted for the record for your response.

Mr. Secretary, I have two requests. First, please send replies to individual questions as soon as they are ready—you do not have to wait until the packages are completed. Second, I would greatly appreciate your prompt attention to the questions as well. Having VA's answers will be extremely helpful as we move forward with our work on the VA budget, and that is the reason for my request.

Last year, we did not receive our responses until summer, and that is simply too late. We want to work together with you on the budget.

Mr. Secretary, I want to thank you and your staff for your responses. We have heard good things in your statements and look forward to working with you to even make it better as we move along here in the budget process.

So thank you again, and we wish you well.

Secretary NICHOLSON. Thank you, Mr. Chairman.

Chairman AKAKA. At this time I would like to call up the second panel.

We have in our next panel Carl Blake, National Legislative Director, Paralyzed Veterans of America; Joseph Violante, National Legislative Director, Disabled American Veterans; David Greineder, Deputy National Legislative Director, AMVETS; and Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars. We also have Steve Robertson, Director, National Legislative Commission, American Legion; and John Rowan, National President, Vietnam Veterans of America.

We welcome all of you to this Committee hearing, and we would like you to begin your testimony in the order that I called your names. First will be Carl Blake.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Mr. Chairman.

Mr. Chairman, Senator Craig, on behalf of the four co-authors of the Independent Budget, I would like to thank you for the opportunity to present our views today regarding the veterans' health care budget for Fiscal Year 2008. Before I begin, I would just like to mention that in the spirit of openness and cooperation, the IBVSOs invited all of the Committee staff members as well as all of the legislative assistants for the Members of the Committee to attend a briefing the week before the President's budget was released to discuss the recommendations of the Independent Budget in advance and to go into some detail about how we develop our budget recommendations, realizing that we have nothing really to hide and ultimately our only interest is to ensure that veterans have the best quality health care and benefits available to them.

It is unfortunate, even as we testify today, that the appropriations bill has still not been completed for the Department of Veterans Affairs, as well as other Federal agencies. Despite the positive outlook in H.J. Res. 20, the VA has been placed in a critical situation where it is forced to cannibalize other accounts in order to continue to provide health care services to veterans. This is jeopardizing not only the health care system, but the actual health care of veterans.

For Fiscal Year 2008, the Administration has requested $34.2 billion for veterans health care, a $1.9 billion increase over the levels established in H.J. Res. 20. Although we recognize this is another step forward, it still falls short of the recommendations of the IB. For Fiscal Year 2008, the IB recommends approximately $36.3 billion, an increase of $4 billion over the Fiscal Year 2007 appropriation level, yet to be enacted, and approximately $2.1 billion over the Administration's request.

For Fiscal Year 2008, the IB recommends approximately $29 billion for medical services. Our medical services recommendation includes $26.3 billion for current services, $1.4 billion for the increase in patient workload, $105 million for additional FTEs, and approximately $1.1 billion for policy initiatives. For medical administration, the IB recommends approximately $3.4 billion, and, finally, for medical facilities the IB recommends approximately $4 billion.

This recommendation also includes an additional $250 million above the Fiscal Year 2008 baseline in order to begin addressing the non-recurring maintenance needs of the VA. Although the IB health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy. The VA estimates that more than 1.5 million Category 8 veterans will have been denied enrollment in the VA health care system by Fiscal Year 2008. Assuming a utilization rate of 20 percent in order to re-

open the system, the IB estimates that VA will require approximately $366 million in discretionary funding.

Although not proposed to have a direct impact on veterans' health care, we are deeply disappointed that the Administration has chosen to once again recommend an increase in prescription drug copayments and an indexed enrollment fee. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system, and more than 1 million veterans will choose not to enroll.

It is astounding that the Administration would continue to recommend policies that would push veterans away from the best health care system in America. Congress has soundly rejected these proposals in the past, and we call on you to do so once again.

For medical and prosthetic research, the Independent Budget is recommending $480 million. This represents a $66 million increase over the Fiscal Year 2007 level established in H.J. Res. 20 and is $69 million over the Administration's request for Fiscal Year 2008. We are very concerned that the medical and prosthetic research account continues to face a virtual flat line in its funding level. Research is a vital part of veterans' health care and an essential mission for our national health care system.

In closing, to address the problem of adequate resources provided in a timely manner, the Independent Budget has once again proposed funding for veterans' health care be removed from the discretionary budget process and be made mandatory. The budget and appropriations process over the last number of years, and particularly this year, demonstrates conclusively how the VA labors under the uncertainty of not only knowing how much money it is going to get, but when it is going to get it.

In the end, it is easy to forget that the people who are ultimately affected by the wrangling over the budget during this process are the men and women who have served and sacrificed so much in defense of this country.

Mr. Chairman, Senator Craig, I would like to thank you again for the opportunity to testify, and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, as one of the four co-authors of The Independent Budget, Paralyzed Veterans of America (PVA) is pleased to present the views of The Independent Budget regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for Fiscal Year 2008.

PVA, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, is proud to come before you this year marking the beginning of the third decade of The Independent Budget, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. The Independent Budget uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 53 Veterans Service Organizations, and medical and health care advocacy groups.

Last year proved to be a unique year for reasons very different from 2005. The VA faced a tremendous budgetary shortfall during Fiscal Year 2005 that was subsequently addressed through supplemental appropriations and additional funds added to the Fiscal Year 2006 appropriations. For Fiscal Year 2007, the Administration

submitted a budget request that nearly matched the recommendations of The Independent Budget. These actions simply validated the recommendations of The Independent Budget once again.

Unfortunately, even as we testify today, Congress has yet to complete the appropriations bill more than one-third of the way through the current fiscal year. Despite the positive outlook for funding as outlined in H.J. Res. 20, the Fiscal Year 2007 Continuing Resolution, the VA has been placed in a critical situation where it is forced to ration care and place freezes on hiring of much needed medical staff. Waiting times have also continued to increase. Furthermore, the VA has had to cannibalize other accounts in order to continue to provide medical services, jeopardizing not only the VA health care system but the actual health care of veterans. It is unconscionable that Congress has allowed partisan politics and political wrangling to trump the needs of the men and women who have served and continue to serve in harm's way.

For Fiscal Year 2008, the Administration has requested $34.2 billion for veterans' health care, a $1.9 billion increase over the levels established in H.J. Res. 20, the continuing resolution for Fiscal Year 2007. Although we recognize this as another step forward, it still falls well short of the recommendations of The Independent Budget. For Fiscal Year 2008, The Independent Budget recommends approximately $36.3 billion, an increase of $4.0 billion over the Fiscal Year 2007 appropriation level yet to be enacted and approximately $2.1 billion over the Administration's request.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health-care funding level. For Fiscal Year 2008, The Independent Budget recommends approximately $29.0 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

(Dollars in Thousands)

Current Services Estimate	$26,302,464
Increase in Patient Workload	1,446,636
Increase in Full-time Employees	105,120
Policy Initiatives	1,125,000
Total fiscal year 2008 Medical Services	$28,979,220

In order to develop our current services estimate, we used the Obligations by Object in the President's Budget to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific accounts within the overall account. Our inflation rates are based on 5-year averages of different inflation categories from the Consumer Price Index-All Urban Consumers (CPI–U) published by the Bureau of Labor Statistics every month.

Our increase in patient workload is based on a 5.5 percent increase in workload. This projected increase reflects the historical trend in the workload increase over the last 5 years. The policy initiatives include $500 million for improvement of mental health services, $325 million for funding the fourth mission (an amount that nearly matches current VA expenditures for emergency preparedness and homeland security as outlined in the 2007 Mid-Session Review), and $300 million to support centralized prosthetics funding.

For Medical Administration, The Independent Budget recommends approximately $3.4 billion. Finally, for Medical Facilities, The Independent Budget recommends approximately $4.0 billion. This recommendation includes an additional $250 million above the Fiscal Year 2008 baseline in order to begin to address the non-recurring maintenance needs of the VA.

Although The Independent Budget health-care recommendation does not include additional money to provide for the health-care needs of Category 8 veterans now being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. VA estimates that more than 1.5 million Category 8 veterans will have been denied enrollment in the VA health-care system by Fiscal Year 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, The Independent Budget estimates that VA will require approximately $366 million. The Independent Budget Veterans Service Organizations (IBVSO) believe the system should be reopened to these veterans and

that this money should be appropriated in addition to our Medical Care recommendation.

Although not proposed to have a direct impact on veterans' health care, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug copayments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1,000,000 veterans will choose not to enroll. It is astounding that this Administration would continue to recommend policies that would push veterans away from the best health care system in the world. Congress has soundly rejected these proposals in the past and we call on you to do so once again.

For Medical and Prosthetic Research, The Independent Budget is recommending $480 million. This represents a $66 million increase over the Fiscal Year 2007 appropriated level established in the continuing resolution and $69 million over the Administration's request for Fiscal Year 2008. We are very concerned that the Medical and Prosthetic Research account continues to face a virtual flatline in its funding level. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in comparison to the growth rate of other Federal research initiatives. We call on Congress to finally correct this oversight.

The Independent Budget recommendation also recognizes a significant difference in our recommended amount of $1.34 billion for Information Technology versus the Administration's recommended level of $1.90 billion. However, when compared to the account structure that The Independent Budget utilizes, the Administration's recommendation amounts to approximately $1.30 billion. The Administration's request also includes approximately $555 million in transfers from all three accounts in Medical Care as well as the Veterans Benefits Administration and the National Cemetery Administration. Unfortunately, these transfers are only partially defined in the Administration's budget justification documents. Given the fact that the veterans' service organizations have been largely excluded from the discussion of how the Information Technology reorganization would take place and the fact that little or no explanation was provided in last year's budget submission, our Information Technology recommendation reflects what information was available to us and the funding levels that Congress deemed appropriate from last year. We certainly could not have foreseen the VA's plan to shift additional personnel and related operations expenses.

Finally, we remain concerned that the Major and Minor Construction accounts continue to be underfunded. Although the Administration's request includes a fair increase in Major Construction from the expected appropriations level of $399 million to $727 million, it still does not go far enough to address the significant infrastructure needs of the VA. Furthermore, the actual portion of the Major Construction account that will be devoted to Veterans Health Administration infrastructure is only approximately $560 million. We also believe that the Minor Construction request of approximately $233 million does little to help the VA offset the rising tide of necessary infrastructure upgrades. Without the necessary funding to address minor construction needs, these projects will become major construction problems in short order. For Fiscal Year 2008, The Independent Budget recommends approximately $1.6 billion for Major Construction and $541 million for Minor Construction.

In closing, to address the problem of adequate resources provided in a timely manner, The Independent Budget has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them.

Making veterans health care funding mandatory would not create a new entitlement, rather, it would change the manner of health care funding, removing the VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process. We look forward to working with this Committee in order to begin the process of moving a bill through the House, and the Senate, as soon as possible.

In the end, it is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of The Independent Budget.

This concludes my testimony. I will be happy to answer any questions you may have.

Chairman AKAKA. Thank you very much, Mr. Blake.

I want our witnesses to know that your full statements will be included in the record.

Mr. Violante?

STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Thank you, Mr. Chairman, Members of the Committee. I am pleased to appear before you on behalf of Disabled American Veterans to summarize our recommendations for Fiscal Year 2008. As mentioned in my written statement, my testimony focuses primarily on the Department of Veterans Affairs benefit programs.

To improve administration of VA's benefit programs, the IB recommends Congress provide the Veterans Benefits Administration with total funding of $1.9 billion in Fiscal Year 2008. Included in our funding recommendations are new resources needed for additional VBA staffing, training programs, and information technologies to correspond with a more effective and efficient benefit delivery system. Mr. Chairman, a core mission of the VA is to provide timely financial disability compensation, dependency and indemnity compensation, and disability pension benefits to veterans and their family members and survivors. VA disability benefits are critical to veterans and their families. We believe meeting the needs of disabled veterans should always be a top priority of the Federal Government.

Mr. Chairman, the backlog is unquestionably growing. Rather than making headway and overcoming the chronic claims backlog and subsequent protracted delays in disposition of claims, VA actually has lost ground on the problem.

We believe that adequate staffing levels are essential to any meaningful strategy to get claims processing and backlogs under control. The IB recommends 10,675 employees for Compensation and Pension.

Mr. Chairman, in addition to boosting its staffing, we believe VBA must continue to upgrade its information technology infrastructure and revise its training tools to stay abreast of modern business practices to maintain efficiency and to meet increasing workload demands. The IB, therefore, recommends that Congress provide $115.4 million for VBA initiatives in Fiscal Year 2008.

To meet its ongoing workload demands and to implement the important initiatives that the VA Vocational Rehabilitation and Employment Task Force recommended, VR&E needs increased staffing. The task force recommended creation and training of 200 new staff position for this purpose. With its increased reliance on contract services, VR&E also needs approximately 50 additional FTEE for management and oversight of contract counselors and employment service providers.

VA has been striving to provide more timely and efficient service to its claimants for education benefits. VBA must increase staffing in its Educational Service to 1,033 employees.

The benefit programs are effective for their intended purposes only to the extent that VBA can deliver benefits to entitled veterans and dependents in a timely fashion. Congress must make adjustments to benefit programs from time to time to address increases in the cost of living and other needed improvements. We invite your attention to our written statement and the Independent Budget itself for details on those issues.

Mr. Chairman, my final concern today is a serious one to the DAV, and also some of our sister organizations. The DAV believes that each veteran who is awarded compensation is entitled to the full payment and that no disabled veteran should be forced to obtain a private attorney to secure an accurate and humane disability rating from VA. Last year, Congress passed Public Law 109–461, which opened the claims process to attorneys.

We at DAV do not believe private attorneys will ease resolution of veterans' claims—and I think the Secretary agreed with that—reduce the claims backlog, nor get these claims resolved on an expeditious basis—the historical intent of Congress. We have been advised by professionals in VBA that adding attorneys to the claims process will only complicate, lengthen, and make resolution of veterans' disability claims more difficult. How such a contentious new direction will actually help sick disabled veterans is beyond our ability to comprehend.

Mr. Chairman, thank you for inviting DAV and the other member organizations of the Independent Budget to testify before the Senate today. I would be happy to answer any questions your Members may have.

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), one of four national veterans organizations that create the annual Independent Budget (IB) for veterans programs, to summarize our recommendations for Fiscal Year (FY) 2008.

As you know Mr. Chairman, the IB is a budget and policy document that sets forth the collective views of DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW). Each organization accepts principal responsibility for production of a major component of our Independent Budget, but it is a budget and policy document on which we all agree. Reflecting that division of responsibility, my testimony focuses primarily on the variety of Department of Veterans Affairs' (VA) benefits programs available to veterans.

In preparing this 21st Independent Budget, the four partners draw upon our extensive experience with veterans' programs, our firsthand knowledge of the needs of America's veterans, and the information gained from continuous monitoring of workloads and demands upon, as well as the performance of, the veterans benefits and services system. As a consequence, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families. We ask that you give our recommendations full and serious consideration again this year.

THE VETERANS BENEFITS ADMINISTRATION IS STILL UNDERSTAFFED AND OVERWHELMED

To improve administration of VA's benefits programs, the IB recommends Congress provide the Veterans Benefits Administration (VBA) $752 million in additional funding in Fiscal Year 2008 compared to the existing Fiscal Year 2007 funding level

(assumed at the time of submission of this statement to be that level approved for VBA by the other Body in H. J. Res. 20, the Continuing Resolution for Fiscal Year 2007, now pending consideration by the Senate). These additional funds, which would raise total funding for VBA to $1.9 billion in Fiscal Year 2008, will provide the means to support a workable long-term strategy for improvement in claims processing and more adequate staffing for the discretionary programs under the jurisdiction of VBA. Included in our funding recommendation are new resources needed for additional VBA staff, training programs and information technologies to correspond with a more effective and efficient benefits delivery system. In total, if Congress accepts our recommendations for necessary funding increases to the General Operating Funds account, these new funds would bring new capabilities to VBA to better serve disabled veterans.

Mr. Chairman, a core mission of VA is to provide financial disability compensation, dependency and indemnity compensation, and disability pension benefits to veterans and their dependent family members and survivors. These payments are intended by law to relieve economic effects of disability (and death) upon veterans, and to compensate their families for loss. For those payments to effectively fulfill their intended purposes, VA should deliver them promptly and based on sound adjudications. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on VA benefits. Also, the need for financial support among disabled veterans can be urgent. While awaiting action by VA on their pending claims, they and their families must suffer hardships; protracted delays can lead to privation and even bankruptcy and homelessness. Some veterans have died while their claims for VA disability compensation or pension were unresolved for years at VA. In sum, VA disability benefits are critical to veterans and their families, Mr. Chairman. We believe meeting the needs of disabled veterans should always be a top priority of the Federal Government.

DIVERSION FROM THE REAL PROBLEM

Recently VA has adopted a tactic of diverting public attention away from the growing claims backlog it holds by demonstrating great speed and efficiency in adjudicating the claims of soldiers and Marines who were severely wounded in the current conflicts in Iraq and Afghanistan. While VA is crowing that it is breaking all records in awarding these new veterans their rightful benefits, hundreds of thousands of claims from older veterans of prior conflicts and military service during earlier periods lie dormant, awaiting a vague future resolution. While we applaud VA's efforts to help new veterans, VA continues to fail older veterans every day that the backlog grows.

Mr. Chairman, the backlog is unquestionably growing. Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in disposition of its claims, VA actually has lost ground on that problem. In fact, looking retrospectively over the past 6 years, the backlog of claims has moved from the December 2000 total of 363,412, to the January 13, 2007 level of 606,239, a more than 80 percent increase during a period when three VA Secretaries of both political parties have stated publicly on multiple occasions that reducing this backlog was their highest management priority. We also note that during this same period as these promises were being made in public, VBA staffing has essentially remained flat at about 9,000 full-time employee equivalents (FTEE). As late as 1 week ago, representatives of our organizations heard senior VA officials brief us on the President's Fiscal Year 2008 budget, with what we could only call "hopeful thinking" that the backlog will be brought under control, but without disclosing any particular plan to fulfill that hope. It will not occur with the level of resources requested by the Administration.

We believe that adequate staffing is essential to any meaningful strategy to get claims processing and backlogs under control. The IB recommends 10,675 FTEE for Compensation and Pension Service (C&P). During Fiscal Year 2004 and Fiscal Year 2005, the total number of compensation, pension, and burial claims received in C&P Service increased by 9 percent, from 735,275 at the beginning of Fiscal Year 2003 to 801,960 at the end of Fiscal Year 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. As the VA Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive." With an aging veteran population and escalating U.S. military operations in Iraq and Afghanistan, we have no reason to believe that growth rate will decline. With a 9 percent increase over the Fiscal Year 2005 number of claims in 2006, VA should be expecting 874,136 claims in C&P

Service in Fiscal Year 2007. Moreover, legislation requiring VA to invite veterans in six States to request review of past claims decisions and to require VA to conduct outreach to invite new claims from other veterans in these States will add substantially to the growing workload. Much of this new workload carried over into Fiscal Year 2007. Also, the Secretary's recent announcement of a special VA outreach effort to ensure non-service connected disability pensioners become aware of their potential eligibility for Aid and Attendance and Housebound benefits is sure to add even more claims to the existing backlog. While we appreciate such outreach efforts, as well as efforts to correct past injustices that may have occurred in particular States, VBA has a co-equal responsibility to ensure it maintains a system capable of managing workload growth. We have not seen that system at work.

In its budget submission for Fiscal Year 2007, VBA projected production based on an output of 109 claims per direct program FTEE. We have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised decisions, higher error and appeal rates, and even more overload on the system. In addition to recommending staffing levels more commensurate with the workload, we have maintained that VA should invest more in training adjudicators and that it should hold them accountable for higher standards of accuracy. In response to survey questions from VA's Office of Inspector General, nearly half of the VBA adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions, with management objectives of maximizing output to meet production standards and reduce backlogs. Nearly half reported that it is generally, or very difficult, to meet production standards without compromising quality. Fifty-seven percent reported difficulty meeting production standards as they attempt to assure they have sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high quality decisions to insufficient staff. Also they indicated that adjudicator training had not been a high priority in VBA.

To allow for more time to be invested in training, we believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTEE. With an estimated 930,000 incoming claims in Fiscal Year 2007, that effort would require 9,300 direct program FTEE in Fiscal Year 2008. With support FTEE added, this would require C&P to be authorized 10,675 total FTEE for Fiscal Year 2008.

Instead of requesting the additional funds and personnel needed to accomplish better results over the past 5 years, the Administration sought, and Congress provided, fewer VBA resources. Recent budgets have requested actual reductions in full-time employees—the workforce that processes claims. Any reductions in VBA staffing would be clearly at odds with the realities of VBA's growing workload and its own well-established adjudication procedures. Adjudication of veterans' claims is a labor-intensive and "hands on" system of personal decisionmaking, with lifelong consequences for disabled veterans. These management and political decisions to cut funding and reduce staffs have contributed to a diminished VA's quality of claims processing and to VA's loss of ground against its backlog. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task at hand. The priorities and goals of the immediate stagnation are at odds with the need for a long-term strategy to fulfill VBA's mission and confirm the Nation's moral obligation to disabled veterans.

Historically, many underlying causes have acted in concert to bring on this seemingly intractable problem. These include poor management, misdirected goals, lack of focus or the wrong focus on cosmetic fixes, poor planning and execution, and outright denial of the existence of the problem—rather than the development and execution of real strategic measures. These dynamics have been thoroughly detailed in several studies and reviews of the continuing problem, but they persist without remedy. While the problem has been exacerbated by lack of action, the IBVSOs believe most of the causes can be directly or indirectly traced to availability of resources. The problem was primarily triggered and is now perpetuated by chronic and insufficient resources.

UNMET NEEDS IN INFORMATION TECHNOLOGY

Mr. Chairman, in addition to boosting its staffing, we believe VBA must continue to upgrade its information technology infrastructure and revise its training tools to stay abreast of modern business practices, to maintain efficiency, and to meet increasing workload demands. In recent years, however, Congress has actually reduced funding for such VBA initiatives. With restored investments in its initiatives,

VBA could complement staffing increases for higher workloads with a support infrastructure designed to increase operational effectiveness. VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrade and enhance training systems, to improve operations and service delivery. Some of these initiatives for priority funding are:

Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with VETSNET for C&P, The Education Expert System (TEES) for Education Service, and Corporate WINRS (CWINRS) for VR&E

VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing claims data

Virtual VA supports pension maintenance activities at three Pension Maintenance Centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically.

TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. This initiative is to modify and enhance TIMS to make it fully interactive to allow for fully automated claims and award processing by Education Service and VR&E nationwide.

Upgrading and enhancement of training systems

VA's Training and Performance Support Systems (TPSS) is a multimedia, multimethod training tool that applies Instructional Systems Development (ISD) methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

VBA initiated its "Skills Certification" instrument in 2004. This tool aids VBA in assessing the knowledge base of Veterans Service Representatives. VBA intends to develop additional skills certification modules to test Rating Veterans Service Representatives, Decision Review Officers, Field Examiners, Pension Maintenance Center employees, and Education Veterans Claims Examiners.

Accelerated implementation of Virtual Information Centers (VICs)

By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA achieves greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

Congress has reduced funding for VBA initiatives every year since 2001, from $82 million in Fiscal Year 2001 to $23 million in Fiscal Year 2006. The IB calls for restoration of funding for this purpose to the 2001 level, with a 5 percent adjustment for each year to cover inflation and increased demands upon the system. The IB therefore recommends that Congress provide $115.4 million for VBA initiatives in Fiscal Year 2008.

The record should show we made many of these same recommendations last year, but unfortunately they did not attract supportive appropriations. The lack of funding for these existing VBA priorities manifests in reinforcing the existing backlogs and failing to serve disabled veterans.

To meet its ongoing workload demands and to implement the important new initiatives the VA Vocational Rehabilitation and Employment Task Force recommended, VR&E needs increased staffing. As a part of its strategy to enhance accountability and efficiency, the Task Force recommended creation and training of 200 new staff positions for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. With its increased reliance on contract services, VR&E also needs approximately 50 additional FTE for management and oversight of contract counselors and employment service providers.

VA has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during Fiscal Year 2004 and Fiscal Year 2005, direct program FTEE were reduced from 708 at the end of Fiscal Year 2003

to 675 at the end of Fiscal Year 2005. Based on experience during Fiscal Year 2004 and Fiscal Year 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in Fiscal Year 2008. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTEE at the end of Fiscal Year 2003 in relation to the workload at that time, VBA must increase direct program staffing in its Education Service in Fiscal Year 2008 to 873 FTEE, 149 more direct program FTEE than authorized for Fiscal Year 2006. With the addition of the 160 support FTEE as currently authorized, Education Service should be provided 1,033 total FTEE for Fiscal Year 2008.

The benefit programs are effective for their intended purposes only to the extent VBA can deliver benefits to entitled veterans and dependents in a timely fashion. However, in addition to ensuring that VBA has the resources necessary to accomplish its mission in that manner, Congress must also make adjustments to the programs from time to time to address increases in the cost of living and needed improvements. We invite your attention to the IB itself for the details of those issues, but the following summarizes a number of recommendations to adjust rates and improve the benefit programs administered by VBA:

- Cost-of-living adjustments for compensation, specially adapted housing grants, and automobile grants, with provisions for automatic annual increases in the housing and automobile grants based on increases in the cost of living.
- A presumption of service connection for hearing loss and tinnitus for combat veterans and veterans who had military duties involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma.
- Removal of the provision that makes persons who first entered service before June 30, 1985, ineligible for the Montgomery GI Bill, along with other improvements to the program.
- No increase in, and eventual repeal of, funding fees for VA home loan guaranty.
- Increase in the maximum coverage and adjustment of the premium rates for Service-Disabled Veterans' Life Insurance.
- Increase in the maximum coverage available on policies of Veterans' Mortgage Life Insurance.
- Legislation to restore protections for veterans' benefits against awards to third parties in divorce actions.
- Legislation to increase Dependency and Indemnity Compensation for certain survivors of veterans, and to no longer offset DIC with Survivor Benefit Plan payments

We hope the Committee will review these recommendations and give them consideration for inclusion in your legislative plans for 2007 and will support their funding in the eventual Congressional Budget Resolution for Veterans Benefits and Services for Fiscal Year 2008.

THE FEDERAL APPEALS COURT FOR VETERANS CLAIMS

Another important component of our system of veterans' benefits is the right to appeal VA's benefits decisions to an independent court. The IB includes recommendations to improve the processes of judicial review in veterans' benefits matters. Again, we invite the Committee's attention to the IB for the details of these recommendations. In addition, the IB recommends that Congress enact legislation to authorize and fund construction of a courthouse and justice center for the United States Court of Appeals for Veterans Claims.

A RELATED AND URGENT CONCERN: ASSURED FUNDING FOR VA MEDICAL CARE

A continuing major concern of this Independent Budget is gaining and keeping adequate funding for veterans medical care. Because the Administration typically seeks funding substantially below the amount necessary to maintain health care services for veterans and because discretionary appropriations have continually fallen short of what is needed, the IB supports legislation to fund VA medical care under a mandatory account or an assured formula to obviate the political wrangling we have observed every year for the past twelve fiscal years, and now including this year as well. Pending his return to duties in the Senate, Senator Tim Johnson of South Dakota has committed to the veterans service organization community his pledge to again introduce a bill this year that would resolve VA health care's chronic funding shortages. Mr. Chairman, as soon as practicable, we urge you to schedule a legislative hearing on this bill, and we ask for an opportunity to testify on its merits.

THE IMPORTANCE OF NATIONAL GUARD AND RESERVE

Benefits Mr. Chairman, the decade-long trend of the Nation's increasing reliance on National Guard, Air National Guard, and the Reserve forces of the Army, Navy and Marine Corps, Air Force and Coast Guard, for national security and disaster call-ups at home, and for peacekeeping and combat deployments overseas, bears no sign of abatement. Our reliance on Guard and Reserve forces has grown since the pre-Persian Gulf War era, and this trend continues even though both Reserve and active duty force levels remain far below their cold war peak.

Since September 11, 2001, over 410,000 individuals who serve in National Guard and Reserve forces have been mobilized for a variety of military, police and security actions. Increasing demands on these serving members impose significant and repeated family separations and create additional uncertainties and interruptions in their civilian career opportunities. Furthermore, Guard and Reserve recruiting, retention, morale and readiness are already at considerable risk. The Nation cannot afford to promote the perception that we undervalue the great sacrifices and level of commitment being demanded from the Guard and Reserve community.

Various incentive, service and benefit programs designed a half century ago for a far different Guard and Reserve philosophy and mission are no longer adequate to address demands on today's Guard and Reserve forces. Accordingly, we believe steps must be taken by Congress to upgrade National Guard and Reserve benefits and support programs to a level commensurate with the sacrifices being made by these patriotic volunteers. Such enhancements should provide Guard and Reserve personnel a level of benefits comparable to their active duty counterparts and provide one means to ease the tremendous stresses now being imposed on Guard and Reserve members and their families, and to bring the relevance of these benefits into 21st century application. With concern about the current missions of the Guard and Reserve forces, Congress must take necessary action to upgrade and modernize Guard and Reserve benefits, to include more comprehensive health care, equivalent Montgomery G.I. Bill educational benefits, and full eligibility for the VA Home Loan guaranty program.

Mr. Chairman, the members of the serving Guard and Reserve forces are now "veterans" for purposes of the benefits and services authorized under Title 38, United States Code. However, the Code was fashioned over the past 65 years primarily to address the needs of the "citizen soldier," an individual who either enlisted in war or was conscripted, served the minimum enlistment or period required, then returned to civilian life as a veteran. The current generation of Guard and Reserve members present very different needs as a consequence of their service, and the kind and variety of service we demand of them as a Nation. We ask the Senate to closely examine the needs of Guard and Reserve members now serving and to consider measures to provide them with effective benefits and services of a grateful government.

ATTORNEYS IN VA CLAIMS

Mr. Chairman, my final concern today is a serious one of DAV and also of some of our sister organizations, but in deference to some that take an alternate view, it is not a major issue in the Independent Budget. As directed by law, VA has a duty to assist veterans in developing and presenting their claims for disability. Congress established the Federal Court discussed above to hear disputes that arise after VA adjudicates those claims, and veterans possess the right by law to appeal their disagreements with decisions and to redress their grievances to a unique Board of Veterans Appeals. That self-checking, unique, system exists because national veterans organizations, including the IBVSOs, have insisted historically that veterans' war injuries and other service-related health problems be dealt with in a humane manner, and without friction or rancor to the greatest extent practicable. Despite the problems we encounter in VBA decisionmaking and operations as related above, we believe that design works, although not as well as intended. The question before the Senate is resources to empower those mechanisms to work better and additional oversight to ensure it works as intended.

The DAV believes that each veteran who is awarded compensation is entitled to full payment, and that no disabled veteran should be forced to obtain a private attorney to secure an accurate and humane disability rating from VA. Nevertheless, against the advice of the DAV and others, last year in Public Law 109–461 Congress authorized private attorneys and agents to engage for pay in veterans' disability claims representation duties, opening the way for significantly altering the foundations of the disability claims adjudication system—a system that has been in place since the founding of the Nation. We at DAV continue to believe this was an unwise action and ask for its repeal.

Mr. Chairman, on adoption of a motion by Representative Stevenson Archer of Maryland, on December 22, 1813, the House of Representatives established the predecessor to its current Committee on Veterans Affairs, for the following stated purpose: "to take into consideration all such petitions, and matters, or things, touching military pensions, and, also claims and demands originating in the Revolutionary War, or arising therefrom, as shall be presented, or shall or may come in question, and be referred to them by the House; and to report their opinion thereupon together *with such propositions for relief therein, as to them shall seem expedient*." [Emphasis added.] What this history demonstrates, Mr. Chairman, is that almost 200 years ago Congress, then playing a primitive executive role, intended to provide disabled Revolutionary veterans their rightful relief—and with expediency. While throughout our history that goal has never flagged, your 21st century injection of private attorneys into that non-adversarial process may serve to change it now.

We at DAV do not believe private attorneys will ease resolution of veterans' claims, reduce the claims backlog, nor get these claims resolved on an expedient basis—the historical intent of Congress. We have been advised by professionals in VBA that your adding attorneys to the claims system will only complicate, lengthen and make more fractious the resolution of veterans' disability claims. As an organization that furnishes 260 National Service Officers to aid veterans with their claims, we believe our own work at DAV will be compromised and made much more expensive once private lawyers enter in. How such an inevitably contentious new direction will actually help sick and disabled veterans receive their just compensation, pension and survivor benefits, we cannot foretell, but we know it will not be easy. We ask the Committee to take legislative action to repeal this measure at the earliest date possible.

Mr. Chairman, thank you for inviting DAV and other member organizations of the Independent Budget to testify before the Senate today. I will be happy to answer any of your or other Members' questions concerning these issues.

Chairman AKAKA. Thank you very much, Mr. Violante.

Mr. Greineder?

STATEMENT OF DAVID G. GREINEDER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. GREINEDER. Thank you. Mr. Chairman, Mr. Craig, Members of the Committee, thank you for inviting AMVETS to this important hearing on VA's budget request for Fiscal Year 2008. As a co-author of the Independent Budget, AMVETS is pleased to give you our best estimates on the resources necessary to carry out the responsibilities of the National Cemetery Administration.

The Administration requests approximately $167 million in discretionary funding for operations and maintenance of the NCA, $167.4 million for major construction, $24.4 million for minor construction, as well as $32 million for the State Cemetery Grants program. The members of the Independent Budget recommend Congress provide $218.3 million for the operational requirements of NCA, a figure that includes our National Shrine Initiative. In total, our funding recommendation represents a $51.5 million increase over the Administration's request.

The national cemetery system continues to be seriously challenged. Adequate resources and developed acreage must keep pace with the increasing workload. The NCA expects to perform nearly 105,000 interments in 2008, an 8.4 percent increase since 2006. By 2009, annual interments are expected to reach 117,000.

Congress also needs to address the need for gravesite renovation and upkeep. Though there has been noteworthy progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Congress has approved funding in recent years aimed to restore the

appearance of national cemeteries, but, frankly, more needs to be done. Therefore, we recommend Congress establish a 5-year, $250 million National Shrine Initiative to restore and improve the condition and character of NCA cemeteries. We recommend $50 million in Fiscal Year 2008 to begin this important initiative. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

For funding the State Cemetery Grants Program, the Independent Budget recommends $37 million for Fiscal Year 2008. The State Cemetery Grants Program is an important component of the NCA. It has greatly assisted States to increase burial services to veterans, especially those living in less densely populated areas not currently served by a national veterans cemetery.

Many States have difficulty meeting the "170,000 veterans within 75 miles" requirement from national cemeteries, which is why the State grant program is so important. Since 1978, the VA has more than doubled the acreage available and accommodated more than a 100 percent increase in their burials through these grants.

The Independent Budget also strongly recommends that Congress review a series of burial benefits that have eroded in value over the years. While these benefits were never intended to cover the full cost of burial, they now pay for just 6 percent of what they covered in 1973. Our recommended increase is modest and will restore the allowance to its original proportion of burial expense, about 22 percent, and will tell veterans that their sacrifice is given the appreciation that is so well deserved.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.7 million soldiers who died in every war and conflict are honored by burial in a national cemetery. Our national cemeteries are more than a final resting place. They are hallowed ground to those who died in our defense and a memorial to those who served.

Mr. Chairman, this concludes my statement. Thank you again.

[The prepared statement of Mr. Greineder follows:]

PREPARED STATEMENT OF DAVID G. GREINEDER,
DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Chairman Akaka, Ranking Member Craig, and Members of the Committee:

AMVETS is honored to join our fellow Veterans Service Organizations and partners at this important hearing on the Department of Veterans Affairs budget request for Fiscal Year 2008. My name is David G. Greineder, Deputy National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of The Independent Budget. This is the 21st year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled their resources together to produce a unique document, one that has stood the test of time.

The IB, as it has come to be called, is our blueprint for building the kind of programs veterans deserve. Indeed, we are proud that over 60 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decisionmakers with a rational, rigorous, and sound review of the budget required to support authorized programs for our Nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health

care services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

Today, I will specifically address the National Cemetery Administration (NCA); however, I would like to briefly comment on the Administration's budget request coming out of the Office of Management and Budget (OMB) just 3 days ago.

Everyone knows that the VA healthcare system is the best in the country, and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system can provide a wide array of specialized services to veterans like those with spinal cord injuries and blindness. This type of care is very expensive and would be almost impossible for veterans to obtain outside of VA.

Because veterans depend so much on VA and its services, AMVETS believes it is absolutely critical that the VA healthcare system be fully funded. It is important our Nation keep its promise to care for the veterans who made so many sacrifices to ensure the freedom of so many. With the expected increase in the number of veterans, a need to increase VA health care spending should be an immediate priority this year. We must remain insistent about funding the needs of the system, and the recruitment and retention of vital health care professionals, especially registered nurses. Chronic under funding has led to rationing of care through reduced services, lengthy delays in appointments, higher copayments and, in too many cases, sick and disabled veterans being turned away from treatment.

Looking at the Administration's budget released last Monday, The Independent Budget recommends Congress provide $36.3 billion to fund VA medical care for Fiscal Year 2008. We ask you to recognize that the VA healthcare system can only bring quality health care if it receives adequate and timely funding.

The best way to ensure VA has access to adequate and timely resources is through mandatory, or assured, funding. I would like to clearly state that AMVETS along with its Independent Budget partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has been inconsistent and inadequate for far too long. Most importantly, mandatory funding would provide a comprehensive and permanent solution to the current funding problem.

THE NATIONAL CEMETERY ADMINISTRATION

The Independent Budget acknowledges the dedicated and committed NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and increasing workload. The devoted staff provides aid and comfort to hurting veterans' families in a very difficult time, and we thank them for their consolation.

The NCA currently maintains more than 2.7 million gravesites at 124 national cemeteries in 39 states and Puerto Rico. At the end of 2007, 66 cemeteries will be open to all interments; 16 will accept only cremated remains and family members of those already interred; and 43 will only perform interments of family members in the same gravesite as a previously deceased family member.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 102,000 in 2006 to 117,000 in 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

The NCA is responsible for five primary missions:

(1) To inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites;

(2) To mark graves of eligible persons in national, state, or private cemeteries upon appropriate application;

(3) To administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries;

(4) To award a Presidential certificate and furnish a United States flag to deceased veterans; and

(5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

NCA Budget Request

The Administration requests $166.8 million for the NCA for Fiscal Year 2008. The members of The Independent Budget recommend that Congress provide $218.3 million and 30 FTE for the operational requirements of NCA, the National Shrine Initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

In accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, The Independent Budget again recommends Congress establish a 5-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget.

It should be noted that the NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

THE STATE CEMETERY GRANTS PROGRAM

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials through this program.

To help provide reasonable access to burial options for veterans and their eligible family members, The Independent Budget recommends $37 million for the SCGP for Fiscal Year 2008. The availability of this funding will help states establish, expand, and improve state-owned veterans' cemeteries.

Many states have difficulties meeting the requirements needed to build a national cemetery in their respective state. The large land areas and spread out population in these areas make it difficult to meet the "170,000 veterans within 75 miles" national veterans cemetery requirement. Recognizing these challenges, VA has implemented several incentives to assist states in establishing a veterans cemetery. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration.

Burial Benefits

There has been serious erosion in the value of the burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the Federal Government first started paying burial benefits for our veterans.

In 2001, the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. The Independent Budget recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973.

In the 108th Congress, the burial allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. The Independent Budget recommends increasing the service-connected burial benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The non-service-connected burial allowance was last adjusted in 1978, and also covers just 6 percent of funeral costs. The Independent Budget recommends increasing the non-service-connected burial benefit from $300 to $1,270.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.7 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans, they are hallowed ground to those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman AKAKA. Thank you very much, Mr. Greineder.

And now Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you very much, Chairman Akaka, Senator Craig, distinguished Members of the Committee. It is certainly a pleasure to be here today on behalf of the men and women of the Veterans of Foreign Wars and the constituent members of the Independent Budget to discuss our recommendations on construction.

The Department of Veterans Affairs construction budget for the past few years has been dominated by the CARES process. Throughout CARES, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did devote many resources to VA's infrastructure, preferring to wait for final results of CARES—sorry—I meant to say, did not devote any resources to VA's infrastructure.

In passing Independent Budgets, we warned against this, pointing out that there were a number of legitimate construction needs identified by local managers of VA facilities. A number of facilities were authorized, but funding was never appropriated with the ongoing CARES being used as the primary excuse. Within this context, and while generally appreciative of a good budget recommendation by the Administration, we must point out that the Fiscal Year 2008 budget for the construction portion is far from adequate.

Chairman Akaka, you have our written statement. I will just now highlight some of our major concerns in this context.

In putting our construction recommendations together, we have our own in-house expertise, but we far from rely upon that alone. We also consult people outside of the VSO community. We look at things like the Pricewaterhouse study. The Presidential Task Force on VA has been a terrific source of information with respect to coming up with our calculations, our percentile adjustments on VA construction.

When we are looking at the shape of VA facilities, we look at VA's own Facility Condition Assessment document as best we can lay our hands on it to come up with projections on that.

We can tell you that Pricewaterhouse among others have pointed out that VA does not recapitalize its physical plant quickly enough. The Presidential Task Force, for example, recommends a recapitalization rate of 5 to 8 percent. I believe that at this time VA only recapitalizes—keeps up its infrastructure at a rate of about half of a percent, which would mean an average VA facility would have to last about 155 years.

For the medical portion of the construction budget, the IB recommends a 4 percent recapitalization rate. Well, that is about $1.4 billion. To emphasize this, we point to the fact that in 2004, then-Secretary Principi said before the House Veterans' Affairs Committee that major construction for VA under CARES would have to be at $1 billion a year for 5 years to keep up. In 2004, the VA got about $750 million for this purpose, and in subsequent years it was only about $.5 billion a year. So it is far below what was needed.

With respect to major construction for medical care, this year the President's budget only asks for about $5.11 million for medical care, and it is far below what we are asking for, as I just mentioned the amount of $1.4 billion, which is actually a rather modest request.

Lastly, we would point to the fact that the 2007 capital plan, that would only fund 8 of the partially funded projects out of the top list of 20. Furthermore, in the 2008 capital plan, again, the President's budget recommendation is only $511 million. This would only fund 6 projects of the 12 partially funded that, as I just mentioned, are receiving some funding. Six others are not funded at all. And in that Capital Asset Plan, with respect to scored projects, those projects which have some sort of priority of attention, none of 27 is funded. So, in short, there is no funding for new projects in the 2008 budget. We find that to be highly problematic.

I will touch briefly on minor construction. The Capital Plan illuminates some 300 projects. The IB calls for $450 million to address these—again, a modest request. We point to the fact that the Administration's budget for this purpose would only be about $180 million, again, for VHA.

Another point here, in the initial planning document of CARES, it was there indicated that VA should have $2 billion under minor construction alone. Again, it is clear that we are falling behind in this capacity.

Mr. Blake earlier talked about non-recurring maintenance. Again, this is a very serious concern. Industry standard, this should occur at about a rate of 2 to 4 percent per year or $800 million to $1.6 billion. The VA's own Capital Asset Management Plan indicates $800 million to $1.6 billion a year in keeping with that calculation. Again, the Administration's budget only calls for about $573 million, falling far short.

There are other things I would like to touch on, Mr. Chairman, but I see the red light blinking. Thank you very much.

[The prepared statement of Mr. Cullinan follows:]

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the United States (VFW), this Nation's largest combat veterans' organization, I would like to thank you for the opportunity to testify today on the Fiscal Year 2008 budget for the Department of Veterans Affairs (VA).

The VA construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a system-wide, data-driven assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, The Independent Budget Veterans Service Organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

• 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
• 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
• 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
• 2004—February: VA Secretary receives CARES Commission recommendations.
• 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES Web site, *www.va.gov/cares*. As of December 2006, only ten of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES Decision document and its established priorities, or with the findings of the CARES Review Commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and Members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past Independent Budgets we warned against this, pointing out that there were a number of legitimate construction needs identified by the local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note this year that both Veterans' Committees have considered legislation that would authorize resumption of VA major medical facility construction projects, but with the breakdown of the appropriations process, these projects died with the end of the 109th Congress.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in Fiscal Year 2007, the Administration recommended a paltry $399 million for major construction.

After that 5-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for con-

struction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

Category	Funding (dollars in thousands)
CARES	1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
Total	$1,602,000

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its 5–year capital plan in Fiscal Year 2008.

Category	Funding (dollars in thousands)
CARES/Non-CARES	450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
Total	$541,000

Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for our Nation's veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that health care can be provided in safe and functional facilities long into the future.

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Pricewaterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the life span of VA's facilities. Exam-

ples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under the Medical Care account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for health care, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.

VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget Veterans Service Organizations (IBVSOs) continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73 critical VA facilities that, based on FEMA definitions, are at a "moderately high" or greater risk of seismic incident. Twenty-four of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of health care and services as well as for cost-effectiveness, it also results in higher upfront project costs, which would require an increase in the construction budget.

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections.

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and shortsighted construction planning.

The Independent Budget Veterans Service Organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities,

for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified need, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program and a more comprehensive examination as part of a master plan later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of these important programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The Commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."

Moreover, the Commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

We also concur with the CARES Commission's recommendations that VA take action to ensure consistent availability of mental health services across the system to include mental health care at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental health care services, especially with the unprecedented current need for these services, and the likely tremendous long-term need of our returning servicemembers.

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect of everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

VA should develop a plan for addressing its excess space in non-historic properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/spinal cord disorders.

With the largest health-care system in the U.S., VA has an advantage in its ability do develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designer, clinician, staff, and management during the design process. These design guides, which are viewable on the Facilities Management Web page, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in over a decade, despite the massive transition of the VA health-care system from an inpatient-based system. The Independent Budget Veterans Service Organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at spinal cord injury/dysfunction (SCI/D) centers. It is important that these guides

be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

The Department of Veterans Affairs' extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great Nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget Veterans Service Organizations recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108–422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage, and encourage its use.

VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the Committee may have.

Chairman AKAKA. Thank you. Thank you very much for your testimony.

Mr. Robertson?

STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION

Mr. ROBERTSON. Thank you, Mr. Chairman, for the invitation. I would like to submit also for the record my official opening remarks, and instead I would like to talk more to the issues that were addressed at the initial panel.

The comment about change, I have been here 19 years working in the legislative arena, and in that 19 years, there has been a lot

of change. When I first came here, the biggest complaint I got from legionnaires around the country was the quality of care in the VA system. Now, people are trying to get into the system, and that is their biggest complaint. The quality of care is superb, and it is well documented. But a lot of the changes we have made have been good changes. Senator Craig, the only thing that I have not seen change is the way we go about funding the system, and that is driving me insane. I will give you an example: third-party collections.

You know, when eligibility reform was passed in 1996, it was a good idea. It opened the system and made it easier to get the quality of care, the right place, the right type of care. It moved to an outpatient system where we were being proactive rather than reactive to treating patients, and we looked at ways to fund this. And at the time of eligibility reform, we really thought we were going to get Medicare reimbursements. We thought we would be reimbursed by all the insurance companies that participated. We even thought that the veterans that did not have insurance would be able to pay some toward the health care that they got.

But, unfortunately, what we wound up with was a third-party collection goal that is very rarely achieved and is deducted from the appropriations. So, I mean, yes, we made a good change, but it turned around biting us. When you have a shortage in third-party collections, that is a real shortage.

The issue of this enrollment fee—and I hear terms being switched around, calling it a "premium" or "enrollment" fee—what it is, is a user fee. You are paying to be able to use the system. And, unfortunately, there are service-connected veterans that are in Priority Groups 7 and 8, and at the rollout, I asked a specific question: "Would the 0 percent service-connected non-compensable be required to pay the enrollment fee?" And the answer was yes. And I would encourage the Committee to write that question and get it in black and white from the Secretary so we have it documented for the record.

Medicare-eligible people that pay Part A, Part B, and Part D would also have to pay the Government once again to access the system that many of them were in the Greatest Generation that saved the country. And you are going to require them to pay this extra fee to the Government.

Then you have got other people that have other insurance, TRICARE, TRICARE for Life, FEHBP. If they want to come to the VA, "the best health care system in the country," you are going to tack on whatever amount of money that they are going to have to pay as an additional user fee for a system that they are entitled to have.

You also have veterans that file a claim, a disability claim, and they are waiting on that claim to be decided. They may also be Priority Group 8s or 7s, and you are, again, asking them to pay while you are waiting for their claim to be finalized.

Then you have recently separated veterans that did not serve in OEF/OIF. They may not even be able to enroll because they did not go overseas.

The one thing I learned about the military is once you raise your hand and say, "I will serve this country," from that point on you

do not have another decision in the military except when you are ready to leave. So where you get assigned is not your choice. It is the Government's choice. But yet these veterans, even though their honorable military service may have occurred in a missile field in North Dakota, they are being denied access to a system that they should have access to.

The increased number of claims, Senator Craig, that you asked about, that is kind of a self-induced thing because now we have said that the only way you can enroll in the system is if you are service-connected or economically indigent. So it is an incentive for people to file a claim so that they can qualify to go to the system that was there for them from the very beginning.

There is also a lot of people who are facing up to disabilities that they previously had ignored. They were doing the John Wayne thing, you know: "I fought the war. I won. I will go home now." But now whatever medical condition is manifested to where they need to have access to the system.

There are also court decisions that drive claims to be reprocessed through that had originally been denied, but because of medical research, whatever, those claims now are valid. So they were denied initial access, and that is why they are refiling their claim, because it is the right thing to do.

Mr. Chairman, I got to tell you, you have got a tough act to follow in Senator Craig. In my 19 years, I don't remember a Chairman holding as many hearings as Senator Craig held as Chairman. So you have got a tough act to follow. But you have got the staff and the people around you to make it work.

Senator CRAIG. I am here to help him. There will be more.

[Laughter.]

Mr. ROBERTSON. Thank you, Mr. Chairman. That concludes my remarks.

[The prepared statement of Mr. Robertson follows:]

PREPARED STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION

Mr. Chairman and Members of the Committee:

I thank you for this opportunity to present the views of its 2.7 million members on the President's Fiscal Year 2008 budget request.

The President's Fiscal Year 2008 budget request is designed to allow VA to address its three highest priorities:

- Provide timely, high-quality health care to veterans who need VA the most—those with service-connected disabilities, lower incomes, special health care needs, and service in Operation Iraqi Freedom and Operation Enduring Freedom.
- Address the significant increase in claims for compensation and pension.
- Ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.

The American Legion will continue to work with the Secretary, Congress and the entire veterans' community to ensure that VA is indeed capable of providing the highest quality health care services ". . . for him who shall have borne the battle and for his widow and his orphan." In 1996, Eligibility Reform was enacted to reopen the VA health care system to all eligible veterans within existing appropriations. Therefore, the challenge faced is to make sure no veteran in need of health care is ever turned away from a VA medical care facility as a result of budgetary shortfalls.

There is no question that all service-connected disabled veterans and economically disadvantaged veterans must receive timely access to quality health care; however, their comrades-in-arms should also receive their earned benefit—enrollment in the VA health care delivery system. Rather than supporting legislative proposals designed to drive veterans from the world's best health care delivery system, The

American Legion will continue to advocate new revenue streams to allow any veteran to receive VA health care.

Equally as important, The American Legion remains steadfastly in support of achieving timely adjudication of VA disability claims and pensions. As a nation at war, the expectation of an increase in the number of new disability claims is apparent. The newest generation of wartime veterans rightly deserve timely adjudication of their claims. Again, the Secretary, Congress and the veterans' community must work toward meaningful solutions to the ever-increasing backlog of veterans' disability claims. Increased funding and additional staffing is a solid first step toward change.

The American Legion fully supports the goals of the National Cemetery Administration. The addition of new national cemeteries and state veterans' cemeteries is critical in meeting the growing need.

With that in mind, The American Legion offers the following budgetary recommendations for selected discretionary programs within the Department of Veterans Affairs for Fiscal Year 2008:

Program	FY06 Funding	President's Request	Legion's Request
Medical Care	$30.8 billion	36.6 billion	38.4 billion
Medical Services	22.1 billion	27.2 billion	29 billion
Medical Administration	3.4 billion	3.4 billion	3.4 billion
Medical Facilities	3.3 billion	3.6 billion	3.6 billion
Medical Care Collections	(2 billion)	(2.4 billion)	2.4 billion*
Medical and Prosthetics Research	412 million	411 million	472 million
Construction:			
Major	1.6 billion	727 million	1.3 billion
Minor	233 million	233 million	279 million
State Extended Care Facilities Grant Program	85 million	85 million	250 million
State Veterans' Cemetery Grants Program	32 million	32 million	42 million
National Cemetery Administration	149 million	166 million	178 million
General Administration	294 million	274 million	300 million
Information Technology	1.2 billion	1.9 billion	1.9 billion

*Third-party reimbursements should supplement rather than offset discretionary funding.

MEDICAL CARE

The Department of Veterans Affairs' standing as the Nation's leader in providing safe, high-quality health care in the health care industry (both public and private) is well documented. Now VA is also recognized internationally as the benchmark for health care services:

• December 2004, RAND investigators found that VA outperforms all other sectors of the U.S. health care industry across a spectrum of 294 measures of quality in disease prevention and treatment;

• In an article published in the *Washington Monthly* (Jan./Feb. 2005) "The Best Care Anywhere" featured the VA health care system;

• In the prestigious *Journal of the American Medical Association* (May 18, 2005) noted that VA's health care system has ". . . quickly emerged as a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs and the establishment of four patient-safety research centers.";

• The *U.S. News* and *World Report* (July 18, 2005) issue included a special report on the best hospitals in the country titled "Military Might—Today's VA Hospitals Are Models of Top-Notch Care" highlighting the transformation of VA health care;

• *The Washington Post* (Aug. 22, 2005) ran a front-page article titled "Revamped Veterans' Health Care Now a Model" spotlights VA health care accomplishments;

• In 2006, VA received the highly coveted and prestigious "Innovations in American Government" Award from Harvard's Kennedy School of Government for its advanced electronic health records and performance measurement system; and

• Recently, in January 2007, the medical journal *Neurology* wrote: "The VA has achieved remarkable improvements in patient care and health outcomes, and is a cost-effective and efficient organization."

Although VA is considered a national resource, the Secretary of Veterans Affairs continues to prohibit the enrollment of any new Priority Group 8 veterans, even if they are Medicare-eligible or have private insurance coverage. This prohibition is

not based on their honorable military service, but rather on limited resources provided to the VA medical care system. For 2 years following receiving an honorable discharge, veterans from Operations Enduring Freedom and Iraqi Freedom are able to receive health care through VA, but many of their fellow veterans and those of other armed conflicts may very well be denied enrollment due to limited existing appropriations. This is truly a national tragedy.

As the Global War on Terrorism continues, fiscal resources for VA will continue to be stretched to their limits and veterans will continue to go to their elected officials requesting additional money to sustain a viable VA capable of caring for all veterans, not just the most severely wounded or economically disadvantaged. VA is often the first experience veterans have with the Federal Government after leaving the military. This Nation's veterans have never let this country down; Congress and VA should do its best to not let veterans down.

The President's budget request for Fiscal Year 2008 calls for Medical Care funding to be $36.6 billion, which is about $1.8 billion less than The American Legion's recommendation of $38.4 billion. The major difference is the President's budget requests continues to offset the discretionary appropriations by its Medical Care Collection Fund's goal ($2.4 billion), whereas The American Legion considers this collection as a supplement since it is for the treatment of nonservice-connected medical conditions.

Medical Services

The President's budget request assumes the enrollment of new Priority Group 8 veterans will remain suspended. The American Legion strongly recommends reconsidering this "lockout" of eligible veterans, especially for those veterans who are Medicare-eligible, military retirees enrolled in TRICARE or TRICARE for Life, or have private health care coverage. Successful seamless transition from military service should not be penalized, but rather encouraged. This prohibition sends the wrong message to recently separated veterans. No eligible veteran should be "locked out" of the VA health care delivery system.

The VA health care system enjoys a glowing reputation as the best health care delivery system in the country, so why "lock out" any eligible veteran, especially those that have the means to reimburse VA for services received? New revenue streams from third-party reimbursements and copayments can supplement the "existing appropriations," but sound fiscal management initiatives are required to enhance third-party collections of reasonable charges.

In Fiscal Year 2008, VA expects to treat 5.8 million patients (an increase of 2.4 percent). According to the President's budget request, VA will treat over 125,000 more Priority 1–6 veterans in 2008 representing a 3.3 percent increase over the number of these priority veterans treated in 2007. Priority 7 and 8 veterans are projected to decrease by over 15,000 or 1.1 percent from 2007 to 2008. However, VA will provide medical care to non-veterans; this population is expected to increase by over 24,000 patients or 4.8 percent over this same time period. In 2008, VA anticipates treating 263,000 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, an increase of 54,000 patients, or 25.8 percent, over the 2007 level.

The American Legion supports the President's mental health initiative to provide $360 million to deliver mental health and substance abuse care to eligible veterans in need of treatment of seriously mental illness, to include post-traumatic stress disorder.

The American Legion remains opposed to the concept of charging an enrollment fee for an earned benefit. Although the President's new proposal is a tiered approach targeted at Priority Groups 7 and 8 veterans currently enrolled, the proposal does not provide improved health care coverage, but rather creates a fiscal burden for the 1.4 million Priority Groups 7 and 8 patients. This initiative clearly projects further reductions in the number of Priority Groups 7 and 8 veterans leaving the system for other health care alternatives. This proposed vehicle for gleaning of veterans would apply to both service-connected disabled veterans as well as nonservice-connected disabled veterans in Priority Groups 7 and 8.

The American Legion also remains opposed to the President's proposed increase in VA pharmacy copays from the current $8 to $15 for enrolled Priority Groups 7 and 8 veterans. This proposal would nearly double current pharmacy costs to this select group of veterans.

The American Legion recommends $29 billion for Medical Services, $1.8 billion more than the President's budget request of $27.2 billion.

Medical Administration

The President's budget request of $3.4 billion is a slight increase in Fiscal Year 2006 funding level. VA plans to transfer 3,721 full-time equivalents from Medical Administration to Information Technology in Fiscal Year 2008. The American Legion applauds the President recommending this level of funding.

Medical Facilities

The President's budget request of $3.6 billion is about $234 million more than the Fiscal Year 2006 funding level. The American Legion agrees with this recommendation to maintain VA existing infrastructure of 4,900 buildings and over 15,700 acres. In Fiscal Year 2008, VA will transfer 5,689 full-time equivalents from Medical Facilities to Medical Services. It has been determined that the costs incurred for hospital food service workers, provisions and related supplies are for the direct care of patients which Medical Services is responsible for providing.

Medical Care Collection Fund (MCCF)

The Balanced Budget Act of 1997, Public Law 105–33, established the VA Medical Care Collections Fund (MCCF), requiring that amounts collected or recovered from third-party payers after June 30, 1997 be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government. The American Legion supported legislation to allow VA to bill, collect, and reinvest third-party reimbursements and copayments; however, The American Legion adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of the collected funds come from the treatment of non-service-connected medical conditions. Historically, these collection goals far exceed VA's ability to collect accounts receivable.

In Fiscal Year 2006, VA collected nearly $2 billion, a significant increase over the $540 million collected in Fiscal Year 2001. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans. Miscalculations of VA required funding levels results in real budgetary shortfall. Seeking annual emergency supplemental is not the most cost-effective means of funding the Nation's model health care delivery system.

Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found an inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

The American Legion opposes offsetting annual VA discretionary funding by the arbitrarily set MCCF goal, especially since VA is prohibited from collecting any third-party reimbursements from the Nation's largest federally mandated, health insurer—Medicare.

Medicare Reimbursement

As do most American workers, veterans pay into the Medicare system without choice throughout their working lives, including active-duty. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system, VA is prohibited from collecting any Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. This prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the treatment of allowable, nonservice-connected medical conditions of allowable enrolled Medicare-eligible veterans.

As a minimum, VA should receive credit for saving the Centers for Medicare and Medicaid Services billions of dollars in annual mandatory appropriations.

MEDICAL AND PROTHESTICS RESEARCH

The American Legion believes that VA's focus in research should remain on understanding and improving treatment for conditions that are unique to veterans. The Global War on Terrorism is predicted to last at least two more decades. Servicemembers are surviving catastrophically disabling blast injuries in Iraq, Afghanistan and elsewhere due to the superior armor they are wearing in the combat theater and the timely access to quality triage. The unique injuries sustained by the

new generation of veterans clearly demands particular attention. There have been reported problems of VA not having the state-of-the-art prostheses, like DOD, and that the fitting of the prostheses for women has presented a problems due to their smaller stature.

In addition, The American Legion supports adequate funding for other VA research activities, including basic biomedical research as well as bench-to-bedside projects. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others jointly with DOD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $472 million for Medical and Prosthetics Research in Fiscal Year 2008, $61 million more than the President's budget request of $411 million.

CONSTRUCTION

Major Construction

Over the past several years, Congress has kept a tight hold on the purse strings that control the funding needs for the construction program within VA. The hold out, presumably, is the development of a coherent national plan that will define the infrastructure VA will need in the decades to come. VA has developed that plan and it is CARES. The CARES process identified more than 100 major construction projects in 37 states, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over $7 million. Now that VA has a plan to deliver health care through the year 2022, it is up to Congress to provide adequate funds. The CARES plan calls for, among other things, the construction of new hospitals in Orlando and Las Vegas and replacement facilities in Louisville and Denver for a total cost estimate of well over $1 billion alone for these four facilities. VA has not had this type of progressive construction agenda in decades. Major construction money can be significant and proper utilization of funds must be well planned out. The American Legion is pleased to see six medical facility projects (Pittsburgh, Denver, Orlando, Las Vegas, Syracuse, and Lee County, FL) included in this budget request.

In addition to the cost of the proposed new facilities are the many construction issues that are virtually "put on hold" for the past several years due to inadequate funding and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. Hurricane Katrina taught a very real lesson on the unacceptable consequences of procrastination. The delivery of health care in unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much-needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable.

The American Legion believes that VA has effectively shepherded the CARES process to its current state by developing the blueprint for the future delivery of VA health care—it is now time for Congress to do the same and adequately fund the implementation of this comprehensive and crucial undertaking.

The American Legion recommends $1.3 billion for Major Construction in Fiscal Year 2008, $573 million more than the President's budget request of $727 million to fund more pending "life-safety" projects.

Minor Construction

VA's minor construction program has suffered significant neglect over the past several years as well. The requirement to maintain the infrastructure of VA's buildings is no small task. Because the buildings are old, renovations, relocations and expansions are quite common. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and well overdue.

The American Legion recommends $279 million for Minor Construction in Fiscal Year 2008, $46 million more than the President's budget request of $233 million to address more CARES proposal minor construction projects.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

In March 1999, GAO published a report on VA's need to improve capital asset planning and budgeting. GAO estimated that over the next few years, VA could spend one of every four of its health care dollars operating, maintaining, and im-

proving capital assets at its national major delivery locations, including 4,700 buildings and 18,000 acres of land nationwide.

Recommendations stemming from the report included the development of asset-restructuring plans for all markets to guide future investment decisionmaking, among other initiatives. VA's answer to GAO and Congress was the initiation and development of the Capital Asset Realignment for Enhanced Services (CARES) program.

The CARES initiative is a blueprint for the future of VHA—a fluid, work in progress, in constant need of reassessment. In May 2004, the long awaited final CARES decision was released. The decision directed VHA to conduct 18 feasibility studies at those health care delivery sites where final decisions could not be made due to inaccurate and incomplete information. VHA contracted PricewaterhouseCoopers (PwC) to develop a broad range of viable options and, in turn, develop business plans based on a limited number of selected options. To help develop those options and to ensure stakeholder input, then-VA Secretary Principi constituted the Local Advisory Panels (LAPs), which are made up of local stakeholders. The final decision on which business plan option will be implemented for each site lies with the Secretary of Veterans Affairs.

The American Legion is dismayed over the slow progress in the LAP process and the CARES initiative overall. Both Stage I and Stage II of the process include two scheduled LAP meetings at each of the sites being studied with the whole process concluding on or about February 2006.

It wasn't until April 2006, after nearly a 7-month hiatus, that Secretary Nicholson announced the continuation of the services at Big Spring, Texas, and like all the other sites, has only been through Stage I. Seven months of silence is no way to reassure the veterans' community that the process is alive and well. The American Legion continues to express concern over the apparent short-circuiting of the LAPs and the silencing of the stakeholders. The American Legion intends to hold accountable those who are entrusted to provide the best health care services to the most deserving population—the Nation's veterans.

Upon conclusion of the initial CARES process, then-Secretary Principi called for a "billion dollars a year for the next 7 years" to implement CARES. The American Legion continues to support that recommendation and encourages VA and Congress to "move out" with focused intent.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes and contracts with public and private nursing homes. The reason for this is obvious; VA paid a per diem of $59.48 for each veteran it placed in State Veterans' Homes, compared to the $354 VA pays to maintain a veteran for 1 day in its own nursing home care units.

Under the provisions of title 38, United States Code, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans' Homes. Today, there are 109 State Veterans' Homes in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans homes. Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans' Home Program be maintained as a viable and important alternative health care provider to the VA system. The American Legion opposes any attempts to place moratoria on new State Veterans' Home construction grants. State authorizing legislation has been enacted and state funds have been committed. The West Los Angeles State Veterans' Home, alone, is a $125 million project. Delaying this and other projects could result in cost overruns from increasing building materials costs and may result in states deciding to cancel these much needed facilities.

The American Legion supports:

- Increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes;
- The provision of prescription drugs and over-the-counter medications to State Veterans' Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and
- Allowing for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans' Home.

The American Legion recommends $250 million for the State Extended Care Facility Construction Grants Program in Fiscal Year 2008, $165 million more than the President's budget request. This additional funding will address more pending life-safety projects and new construction projects.

STATE CEMETERY GRANTS PROGRAM

The State Veterans' Cemetery Grant Program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. States are planning to open 24 new state veterans' cemeteries between 2007 and 2012. There are 60 operational cemeteries and two more under construction. Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $42 million for the State Cemetery Grants Program in Fiscal Year 2008, $10 million more than the President's budget request.

NATIONAL CEMETERY ADMINISTRATION

The mission of the National Cemetery Administration is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to this Nation. The National Cemetery Administration's vision is to serve all veterans and their families with the utmost dignity, respect, and compassion. Every national cemetery should be a place that inspires visitors to understand and appreciate the service and sacrifice of this Nation's veterans.

National Cemetery Expansion

The American Legion supported P.L. 108–109, the National Cemetery Expansion Act of 2003, authorizing VA to establish new national cemeteries to serve veterans in the areas of: Bakersfield, Calif.; Birmingham, Ala.; Jacksonville, Fla.; Sarasota County, Fla.; southeastern Pennsylvania; and Columbia-Greenville, S.C. All six areas have veterans' populations exceeding 170,000, which is the threshold VA has established for new national cemeteries. By 2009, all six new national cemeteries should be open to serve veterans in these areas.

There are approximately 24 million veterans alive today. Nearly 688,000 veteran deaths are estimated to occur in 2008. The total number of graves maintained by VA is expected to increase from 2.8 million in 2006 to just over 3.2 million by 2012. The VA expects that at least 12 percent of these veterans will request burial in a national cemetery. Considering the growing costs of burial services and the excellent quality of service the NCA is providing, The American Legion foresees that this percentage will be much greater. By 2012, four more national cemeteries are expected to exhaust their supply of available, unassigned gravesites.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. The American Legion supports NCA's goal of completing the National Shrine Commitment within 5 years. This commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this commitment.

The American Legion recommends $178 million for the National Cemetery Administration in Fiscal Year 2008, $12 million more than the President's budget request.

INFORMATION TECHNOLOGY

The data theft that occurred in May of last year serves as a monumental wake up call to the Nation. VA can no longer ignore IT security. The recovery of the laptop is indeed cause for optimism; however, we must not discount the possibility that every name on that list could still be subject to possible identity theft. The complete overhaul of VA IT is only in its beginning stages. Meanwhile, there are still unresolved security breaches within VA including the most recent theft of a laptop from a VA contractor. How many computers need to be stolen before veterans get some real assurances from the Federal Government that their information is not only safe, but that safeguards will be in place to help protect them against identity

theft? The American Legion once again calls on VA and the Administration to keep its promise to veterans and provide free credit monitoring for 1 year. The American Legion is hopeful that the steps VA takes to strengthen its IT security will renew the confidence and trust of veterans who depend on VA for the benefits they have earned.

Funding for the IT overhaul should not be paid for with money from other VA programs. This would in essence make veterans pay for VA's gross negligence in the matter. The American Legion hopes that Congress will not attempt to fix this problem on the backs of America's veterans and from scarce fiscal resources provided to the VA health care delivery.

VA has shown it can be a leader in the areas of care and service. Its accomplishments, from providing high quality medical care to leading the world in the development of electronic records, are indicators that VA can also be the Nation's leader in IT security.

The American Legion believes that there should be a complete review of IT security governmentwide. VA isn't the only agency within the government that needs to overhaul its IT security protocol. The American Legion would urge Congress to exercise its oversight authority and review each Federal agency to ensure that the personal information of all Americans is secure.

The American Legion agrees with the President's budget request for $1.9 billion for Information Technology in Fiscal Year 2008.

VA'S LONG-TERM CARE MISSION

Historically, VA's Long-Term Care (LTC) has been the subject of discussion and legislation for nearly two decades. In a landmark July 1984 study, Caring for the Older Veteran, it was predicted that a wave of elderly veterans had the potential to overwhelm VA's long-term care capacity. Further, the recommendations of the Federal Advisory Committee on the Future of Long-Term Care in its 1998 report VA Long-Term Care at the Crossroads, made recommendations that serve as the foundation for VA's national strategy to revitalize and reengineer long-term care services. It is now 2006 and that wave of veterans has arrived.

Additionally, Public Law 106–117, the Millennium Act, enacted in November 1999, required VA to continue to ensure 1998 levels of extended care services (defined as VA nursing home care, VA domiciliary, VA home-based primary care, and VA adult day health care) in its facilities. Yet, VA has continually failed to maintain the 1998 bed levels mandated by law.

VA's inability to adequately address the long-term care problem facing the agency was most notable during the CARES process. The planning for the long-term care mission, one of the major services VA provides to veterans, was not even addressed in the CARES initiative. That CARES initiative is touted as the most comprehensive analysis of VA's health care infrastructure that has ever been conducted.

Incredibly, despite 20 years of forewarning, the CARES Commission report to the VA Secretary states that VA has yet to develop a long-term care strategic plan with well-articulated policies that address the issues of access and integrated planning for the long-term care of seriously mentally ill veterans. The Commission also reported that VA had not yet developed a consistent rationale for the placement of long-term care units. It was not for the lack of prior studies that VA has never had a coordinated long-term care strategy. The Secretary's CARES decision agreed with the Commission and directed VHA to develop a strategic plan, taking into consideration all of the complexities involved in providing such care across the VA system.

The American Legion supports the publishing and implementation of a long-term care strategic plan that addresses the rising long-term care needs of America's veterans. We are, however, disappointed that it has now been over 2 years since the CARES decision and no plan has been published.

It is vital that VA meet the long-term care requirements of the Millennium Health Care Act and we urge this Committee to support adequate funding for VA to meet the long-term care needs of America's Veterans. The American Legion supports the President's $4.6 billion funding recommendation for Fiscal Year 2008.

HOMELESS VETERANS

VA has estimated that there are at least 250,000 homeless veterans in America and approximately 500,000 experience homelessness in a given year. Most homeless veterans are single men; however, the number of single women with children has drastically increased within the last few years. Homeless female veterans tend to be younger, are more likely to be married, and are less likely to be employed. They are also more likely to suffer from serious psychiatric illness.

Approximately 40 percent of homeless veterans suffer from mental illness and 80 percent have alcohol or other drug abuse problems. It cannot go unnoticed that the increase in homeless veterans coincides with the underfunding of VA health care, which resulted in the downsizing of inpatient mental health capabilities in VA hospitals across the country. Since 1996, VA has closed 64 percent of its psychiatric beds and 90 percent of its substance abuse beds. It is no surprise that many of these displaced patients end up in jail, or on the streets. The American Legion applauds VA's recent plan to restore a good portion of this capacity. The American Legion believes there should be a focus on the prevention of homelessness, not just measures to respond to it. Preventing it is the most important step to ending it.

The American Legion has a vision to assist in ending homelessness among veterans by ensuring services are available to respond to veterans and their families in need before they experience homelessness. Toward that objective, The American Legion in partnership with the National Coalition for Homeless Veterans created a Homeless Veterans Task Force. The mission of the Task Force is to develop and implement solutions to end homelessness among veterans through collaborating with government agencies, homeless providers and other Veterans Service Organizations. In the last 2 years, 16 homeless veterans workshops were conducted during The American Legion National Leadership Conferences, National Convention and Mid-Winter Conferences. Currently, there are 51 Homeless Veterans Chairpersons within The American Legion who act as liaison to Federal, state and community homeless agencies and monitor fundraising, volunteerism, advocacy and homeless prevention activities within participating American Legion Departments.

The current Administration has vowed to end the scourge of homelessness within 10 years. The clock is running on this commitment, yet words far exceed deeds. While less than 9 percent of the Nation's population are veterans, 34 percent of the Nation's homeless are veterans and of those 75 percent are wartime veterans.

Homelessness in America is a travesty, and veterans' homelessness is disgraceful. Left unattended and forgotten, these men and women, who once proudly wore the uniforms of this Nation's Armed Forces and defended her shores, are now wandering her streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending homelessness among America's veterans, there is much more that needs to be done. We must not forget them. The American Legion supports funding that will lead to the goal of ending homelessness in the next 10 years.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, P.L. 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

The American Legion strongly supports changing the Grant and Per Diem Program to be funded on a 5-year period instead of annually and a funding level increased to the $200 million level annually.

VETERANS BENEFITS ADMINISTRATION (VBA)

The VA has a statutory responsibility to ensure the welfare of the Nation's veterans, their families, and survivors. Providing quality decisions in a timely manner has been, and will continue to be, one of the VA's most difficult challenges.

Workload and Claims Backlog

There are approximately 3.5 million veterans and beneficiaries currently receiving VA compensation and pension benefits. In 2006, VA added almost 250,000 new beneficiaries to the compensation and pension rolls. VA anticipates receiving about 800,000 claims a year in 2007 and 2008. The current staffing levels do not enable VA to reduce the pending claims inventory and provide timely service to veterans; therefore, the President is requesting an increase of 457 full-time equivalents compensation and pension personnel. The productivity of the additional staff will increase throughout 2008 and in subsequent years as these new employees receive training and gain experience. VA believes the additional staffing will enable VBA to improve claims processing timeliness, reduce appeals workload, improve appeals processing timeliness, and enhance services to veterans returning from the Global War on Terrorism.

The increasing complexity of VA claims adjudication continues to be a major challenge for VA rating specialists. Since judicial review of veterans' claims was enacted in 1988, the remand rate of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC) has, historically, been about 50 percent. In a se-

ries of precedent-setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, a number of longstanding VA policies and regulations have been invalidated because they were not consistent with statute. These court decisions immediately added thousands of cases to regional office workloads, since they require the review and reworking of tens of thousands of completed and pending claims.

As of August 19, 2006, there were more than 389,000 rating cases pending in the VBA system. Of these, 92,047 (23.6 percent) have been pending for more than 180 days. According to the VA, the appeals rate has also increased from a historical rate of about 7 percent of all rating decisions being appealed to a current rate that fluctuates from 11 to 14 percent. This equates to more than 152,000 appeals currently pending at VA regional offices, with more than 132,000 requiring some type of further adjudicative action.

Staffing

Whether complex or simple, VA regional offices are expected to consistently develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner. The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VBA has lost much of its institutional knowledge base over the past 4 years, due to the retirement of many of its 30-plus year employees. As a result, staffing at most regional offices is made up largely of trainees with less than 5 years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their initial training.

Concern over adequate staffing in VBA to handle its demanding workload was addressed by VA's Office of the Inspector General (IG) in a report released in May 2005 (Report No. 05–00765–137, dated May 19, 2005). The IG specifically recommended, "in view of growing demand, the need for quality and timely decisions, and the ongoing training requirements, reevaluate human resources and ensure that the VBA field organization is adequately staffed and equipped to meet mission requirements." The Under Secretary for Benefits has conceded that the number of personnel has decreased over the last few years. And the congressionally mandated Veterans' Disability Benefits Commission is also closely looking at the adequacy of current staffing levels.

It is an extreme disservice to veterans, not to mention unrealistic, to expect VA to continue to process an ever increasing workload, while maintaining quality and timeliness, with less staff. Our current wartime situation provides an excellent opportunity for VA to actively seek out returning veterans from Operations Enduring Freedom and Iraqi Freedom, especially those with service-connected disabilities, for employment opportunities within VBA. To ensure VA and VBA are meeting their responsibilities, The American Legion strongly urges Congress to scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

GI BILL EDUCATION BENEFITS

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. We believe this is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average 4-year public institution as a commuter student during the 1999–2000 academic year was nearly $9,000. On October 1, 2005, the basic monthly rate of reimbursement under MGIB was raised to $1,034 per month for a successful 4-year enlistment and $840 for an individual whose initial active-duty obligation was less than 3 years. The current educational assistance allowance for persons training full-time under the MGIB Selected Reserve is $297 per month.

The Servicemen's Readjustment Act of 1944, P.L. 78–346, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that Act. Consequently, these former servicemembers made a substantial contribution not only to their own careers, but also to the economic well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Be-

tween 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that the government actually made a profit because veterans who had graduated from college generally earned higher salaries and, therefore, paid more taxes.

Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also making a greater contribution to their community, state, and Nation.

The American Legion recommends the 110th Congress make the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify;
- The educational cost index should be reviewed and adjusted annually;
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package;
- Enrollment in the MGIB shall be automatic upon enlistment; however, benefits will not be awarded unless eligibility criteria have been met;
- The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated;
- If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans;
- If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB;
- Separating servicemembers and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device;
- Eligible veterans shall have an unlimited number of years after discharge to utilize MGIB educational benefits;
- Eligible veterans should have the right to transfer their earned benefits to their spouse and dependents; and
- Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years after their date of separation to use MGIB educational benefits.

VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICE (VR&E)

The mission of the VR&E program is to help qualified, service-disabled veterans achieve independence in daily living and, to the maximum extent feasible, obtain and maintain suitable employment. The American Legion fully supports these goals. As a nation at war, there continues to be an increasing need for VR&E services to assist Operations Iraqi Freedom and Enduring Freedom veterans in reintegrating into independent living, achieving the highest possible quality of life, and securing meaningful employment. To meet America's obligation to these specific veterans, VA leadership must focus on marked improvements in case management, vocational counseling, and—most importantly—job placement.

The successful rehabilitation of our severely disabled veterans is determined by the coordinated efforts of every Federal agency (DOD, VA, DOL, OPM, HUD etc.) involved in the seamless transition from the battlefield to the civilian workplace. Timely access to quality health care services, favorable physical rehabilitation, vocational training, and job placement play a critical role in the "seamless transition" of each and every veteran, as well as his or her family.

Administration of VR&E and its programs is a responsibility of the Veterans Benefits Administration (VBA). Providing effective employment programs through VR&E must become a priority. Until recently, VR&E's primary focus has been providing veterans with skills training, rather than providing assistance in obtaining meaningful employment. Clearly, any employability plan that doesn't achieve the ultimate objective—a job—is falling short of actually helping those veterans seeking assistance in transitioning into the civilian workforce.

Vocational counseling also plays a vital role in identifying barriers to employment and matching veterans' transferable job skills with those career opportunities available for fully qualified candidates. Becoming fully qualified becomes the next logical objective toward successful transition.

Veterans Preference in Federal hiring plays an important role in guiding veterans to career possibilities within the Federal Government and must be preserved. There

are scores of employment opportunities within the Federal Government that educated, well-trained, and motivated veterans can fill—given a fair and equitable chance to compete. Working together, all Federal agencies should identify those vocational fields, especially those with high turnover rates, suitable for VR&E applicants. Career fields like information technology, claims adjudications, debt collection, etc., offer employment opportunities and challenges for career-oriented applicants that also create career opportunities outside the Federal Government.

GAO has also cited exceptionally high workloads for a limited number of staff members at VR&E offices. This increased workload hinders the staff's ability to effectively assist individual veterans with identifying employment opportunities. In April 2005, the average caseload of a typical VR&E counselor approached 160 veterans. The American Legion is pleased that an additional number of 150 full-time equivalents will be hired and we applaud the President's budget request for $159.5 million in Fiscal Year 2008. It is vital that Congress approve this request to adequately address the expected increase of veterans needing assistance.

HOME LOAN GUARANTY PROGRAM

VA's Home Loan Guaranty program has been in effect since 1944 and has afforded nearly 17 million veterans the opportunity to purchase homes. The Home Loan programs offer veterans a centralized, affordable and accessible method of purchasing homes in return for their service to this Nation. The program has been so successful over the past years that not only has the program paid for itself but has also shown a profit in recent years. The American Legion believes that it is unfair for veterans to pay high funding fees of 2 to 3 percent, which can add approximate $3,000 to $11,000 for a first-time buyer. The VA funding fee was initially enacted to defray the costs of the VA guaranteed home loan program. The current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program. Therefore, The American Legion strongly recommends that the VA funding fee on home loans be reduced or eliminated for all veterans whether active duty, reservist, or National Guard.

Specially Adapted Housing

The American Legion believes that with the increasing numbers of disabled veterans returning from Iraq and Afghanistan, the need for specially adapted housing is paramount. Therefore, The American Legion strongly recommends that the current $50,000 grant for specially adapted housing be increased to $55,000 and special home adaptations be increased from $10,000 to $12,300. Specially adapted housing grants are available for the installation of wheelchair ramps, chair lifts, modifications to kitchens and bathrooms and other adaptations to homes for veterans who cannot move about without the use of wheelchairs, canes or braces or who are blind and suffer the loss or loss of use of one lower extremity. Special home adaptation grants are available for veterans who are legally blind or have lost the use of both hands.

SUMMARY

Mr. Chairman and Members of the Committee, The American Legion appreciates the strong relationship we have developed with this Committee. With increasing military commitments worldwide, it is important that we work together to ensure that the services and programs offered through VA are available to the new generation of American servicemembers who will soon return home. You have the power to ensure that their sacrifices are indeed honored with the thanks of a grateful Nation.

The American Legion is fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the Nation's call to arms.

Thank you for allowing me the opportunity to appear before you today.

Chairman AKAKA. Thank you very much for your testimony, Mr. Robertson.

Mr. Rowan?

STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Good afternoon. Chairman Akaka and Senator Craig and Senator Brown, thank you for allowing the Veterans Service Organizations to testify this morning on the VA budget, giving us access at the beginning of this process.

While we tend to agree with the IB folks about a lot of their numbers, we believe that they are still a little low. We actually think that we need another $6.9 billion rather than $4 billion, and we have a chart that we have broken out much of that dollars and cents, which we have put in as part of our testimony. One of the biggest chunks is almost $2 million and change to cover these so-called management deficiencies, which were really staff deficiencies, that the VISNs made do with what they could and basically cut staff to fit the budget that they got.

I would also ask the Senate if they could allow us to put into the record as part of our testimony the study by Ms. Linda Bilmes from Harvard Kennedy School of Government on "Soldiers Returning from Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits," a study that she had done, which is pretty enlightening.

Chairman AKAKA. That study will be included in the record.

Mr. ROWAN. Thank you, sir.

As I said, we believe that there is a whole host of reasons why we think this needs more money into this budget that has been proposed, not the least of which is what we think is an undercount in both numbers of new veterans coming into the system and old veterans coming into the system, many for the first time. As I testified last year before this Committee, we believe that Vietnam veterans in particular are coming down with many Agent Orange-related illnesses that they are entitled to get compensation and health care for that are now manifesting themselves today—the whole diabetic problem, the whole problem with prostate cancer, lung cancer, all kinds of other conditions, which in and of themselves must drive up the need for medical care by veterans in the VA system. And, unfortunately, it is very expensive care and often multidisciplinary care, as was pointed out earlier in the Secretary's testimony.

When we file a claim today, a veteran often is not filing a single claim. They are filing multiple claims with multiple issues, either secondary conditions attached to the original condition or multiple different conditions. And so the 800,000 claims we talk about being submitted is really God knows how many actual issues of health care. And what the impact is on the VA health care system has got to be substantial.

So, again, we would like to see a breakdown also of how many people who have been put aside that are no longer eligible for the system and really who they are, this whole dollar-and-cents thing is throwing around it. I doubt very much if there is any $200,000 income family or income veteran running to get to the VA in reality. It has got to be a very small number. And Senator Craig mentioned earlier how the significant percentage of the veterans in the system that are eligible for Medicare only seems to me another reason why we ought to get the Medicare money back into the VA

system. I would venture to say that many of those people are also service-connected disabled veterans who are entitled to health care no matter what. So it will be really interesting to see a more in-depth analysis of all of that.

There were some other issues raised. Senator Murray raised the whole issue about inpatient PTSD programs. There are VISNs in this country that do not have inpatient programs in their VISN, and so we see a lot of time veterans traveling far distances to get inpatient care. Having come from New York, I know that Batavia has an excellent inpatient care program that I know of from dealing with the people in their alumni association who take care of them after they have gone through the program, dealing with veterans from all across this country who come to that facility because it is well known and does a very good job. And they have just opened a new women's facility, which is going to be real interesting to see what happens with that, with, unfortunately, the significant number of women now in the system.

As we wind down, I would also echo what Steve said about the zeros. The zero percenters, one must remember, may have been 100 percenters at one time, and the classic example of that is the prostate cancer person. You get a Vietnam vet who has got prostate cancer gets 100 percent while they are diagnosed with prostate cancer. If they are lucky enough to go through a treatment that takes care of their cancer, they are dropped down to zero. But as everybody will tell you, they need to come back regularly for significant care and review to make sure that their cancer does not come back somewhere else.

Thank you.

[The prepared statement of Mr. Rowan follows:]

PREPARED STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Chairman Akaka, Ranking Member Craig and distinguished Members of the Committee, on behalf of all of our officers, Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify today regarding the President's Fiscal Year 2008 budget request for the Department of Veterans Affairs. I am pleased to welcome so many new and returning Members onto the Committee this year. VVA looks forward to working with all of you to address the needs of the unique system created to serve our Nation's veterans.

Mr. Chairman, several years ago, Vietnam Veterans of America developed a White Paper in support of the need for assured funding for the veterans health care system, which I know you have read and shared with others. I also know you have been a long-time supporter of legislation to achieve assured funding. You have always understood the need for such a mechanism to correct the problems in the current system of funding. As we have this discussion in regard to the FY 2008 budget for VA, the readily apparent need for this legislation has never been more pressing. We look forward to working with you to ensure its enactment.

VVA does wish to recognize that this year's request from the President for the VA Budget, while lacking in many other respects, is relatively free of "budget gimmicks" that have so plagued discussions in the past. VVA believes that this is due to the strong efforts of Secretary Nicholson in doing battle to strip out the favorite "gimcrackery" of that permanent staff over at the Office of Management and Budget (OMB). VVA commends the Secretary of Veterans Affairs in this regard for seeking to have an honestly presented budget proposal.

VETERANS HEALTH ADMINISTRATION

VVA is recommending an increase of $6.9 billion to the expected Fiscal Year 2007 appropriation for the medical care business line. We recognize that the budget recommendation VVA is making this year is extraordinary, but with troops in the field,

years of underfunding of health care organizational capacity, renovation of an archaic and dilapidated infrastructure, updating capital equipment, and several cohorts of war veterans reaching ages of peak health care utilization, these are extraordinary times. It's past time to meet these needs.

In contrast to what is clearly needed, we believe the Administration's Fiscal Year 2008 request for $2 billion more than the expected 2007 appropriation in the continuing resolution is inadequate. Unfortunately, we still are unsure of the bottom line for Fiscal Year 2007. While we certainly appreciate that the Congress is planning to restore funding for veterans health care in the continuing resolution (and it is essential that it does so to ensure the Department's ability to meet ongoing obligations), the fact that VA is still uncertain about the amount of funding it will receive a third of the way through the fiscal year does, virtually in and of itself, make the case for assured funding.

The $2 billion increase the Administration has requested for medical care may almost keep pace with inflation, but it will not allow VA to enhance its health care or mental health care services for returning veterans, restore diminished staff in key disciplines like clinicians needed to care for Hepatitis C, restore needed long-term care programs for aging veterans, or allow working-class veterans to return to their health care system. VVA's recommendation does accommodate these goals, in addition to restoring eligibility to veterans exposed to Agent Orange for the care of their related conditions.

I need not tell you about the many successes of the Department of Veterans Affairs in recent years. The Veterans Service Organizations are often seen as critics of the Department, but while it's true that we sometimes take exception to its policy decisions we are, in fact, also its most stalwart champions. Over the last decade the Veterans Health Administration (VHA) at VA has taken steps to become a higher quality, more accessible health care system. It has demonstrated great efficiency by almost doubling the number of veterans it treats while holding per capita costs relatively constant. It has developed hundreds of Community Based Outreach Clinics (CBOCs). VHA has received many prestigious awards for excellence and innovation. While VVA remains extremely concerned about recent breaches that compromised veterans' personal data, VVA appreciates the fact that VA has put together a computerized system of medical records that sets the standard for modern health care delivery. These achievements are to be celebrated.

Yet, these advances have not come without a cost. For years, the veterans' health care system has been falling behind in meeting the health care needs of some veterans. At the beginning of 2003, the former Secretary of Veterans Affairs made the decision to bar so-called Priority 8 veterans from enrolling. In most cases, these veterans are not the well-to-do—they are working-class veterans or veterans living on fixed incomes as little as $28,000 a year. It's not uncommon to hear about such veterans choosing between getting their prescription drug orders filled and paying their utility bills. The decision to bar these veterans is still standing, and it is still troubling to thoughtful Americans.

In addition to the current bar on health care enrollment, in recent years VA has sent Congress a budget that requires more cost-sharing from veterans, and eliminates options for their care—particularly long-term care. We appreciate that VA's proposal this year has not presumed enactment of some of the cost-sharing legislative proposals Congress has opposed in the past. This may allow Congress more leeway to augment its request in concrete ways rather than merely filling deficits left by the Administration presuming that revenues and savings from these unpopular initiatives will be realized.

Congress is to be commended for turning back many legislative requests for enrollment fees and outpatient cost increases, which would have jeopardized hundreds of thousands of veterans' access to health care. Hard-fought Congressional add-ons, such as the $3.6 billion for Fiscal Year 2007 currently being debated as part of the continuing resolution, have kept the system afloat. The budget recommended by VVA in addition to the enactment of some assured funding mechanism will enable a robust health care system to meet the needs of all eligible veterans—now and in the future.

MEDICAL SERVICES

For medical services for Fiscal Year 2008, VVA recommends $34.5 billion, including collections. This is approximately $5 billion more than the Administration's request. VVA is making its budget recommendations based on re-opening access to the millions of veterans disenfranchised by the Department's policy decision of early 2003 that was supposed to be "temporary." The former ranking member of the House Veterans' Affairs Committee, Lane Evans, discovered that a quarter-million

Priority 8 veterans had applied for care in Fiscal Year 2005. Similar numbers of veterans have likely applied in each of the years since their enrollment was barred. Our budget allows 1.5 million new Priority 7 and 8 veterans to enroll for care in their health care system. While this may sound like too great a lift for the system, use rates for Priority 7 and 8 veterans are much lower than for other priority groups. Based on our estimates, it may yield only an 8 percent increase in demand at a cost of about $1.5 billion to the system for additional personnel, supplies and facilities.

The budget axe has fallen hard on long-term care programs in VA. About a decade ago, there was a major policy shift throughout the health care industry, including with VA, which encouraged programs to deliver as much care as possible outside of beds. In many cases this has been a productive policy. Veterans value the convenience of using nearby community clinics for primary care needs, for example.

However, the change took a great toll on the neuro-psychiatric and long-term care programs that housed and cared for thousands of veterans, often keeping them institutionalized for years. Instead of developing the significant community and outpatient infrastructures that would have been necessary to adequately replace the care for these most vulnerable veterans, the resources were largely diverted to other purposes.

Where have these vets gone? The fiscally challenged Medicaid program supports many of those who need long-term care, adding an additional burden to the states. State homes play an important role in remaining the only VA-sponsored setting that provides ongoing, rather than rehabilitative or restorative, long-term care. VA's mental health programs—some of the finest in the Nation—as well as significant advances in pharmaceutical therapies continue to serve and allow many veterans to recover. However, what are in fact increasing waiting times for mental health programs and the lack of treatment options often contribute to incarceration and homelessness for the most vulnerable of these veterans. Sadly, we hear increasing numbers of stories of veterans of Iraq and Afghanistan whose inability to deal with readjustment post-deployment have lead them to the streets or even suicide.

Mr. Chairman, Vietnam Veterans of America's founding principle is: "Never again will one generation of veterans abandon another." This is why we are imploring this Committee to ensure that VA has the imperative and the resources to bolster the mental health programs that should be readily available to serve our young veterans from Iraq and Afghanistan. Experts from within the Department of Defense estimate that as many as 17 percent of those who serve in Iraq will have issues requiring them to seek post-deployment mental health services and recent studies have shown that four out of five of the veterans who may need post-deployment care are not properly referred to such care. There is good reason to believe that even the rates forecast by DOD may be too low.

VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental health care. Its own internal champions—the Committee on Care of the Seriously Mentally Ill and the Advisory Committee on Post-Traumatic Stress Disorder, for example—have expressed doubts about VA's mental health care capacity to serve these newest vets. As recently as last March, VHA's Undersecretary for Health Policy Coordination told one commission that mental health services were not available everywhere, and that waiting times often rendered some services "virtually inaccessible." The doubts about capacity to serve new veterans have reverberated in reports done by the Government Accountability Office (GAO). In addition, one recent working paper by Linda Bilmes of the John F. Kennedy School of Government at Harvard University estimates that in a "moderate" scenario in 2008 VA will require $1.8 billion to treat the veterans returning from Iraq and Afghanistan—much of this funding would be used to augment mental health care to properly serve these veterans. VA has projected that approximately 260,000 Global War on Terrorism (GWOT) veterans will use the VA health care system in FY 2008. VVA and others believe that well more than 300,000 "new" veterans will use the VHA system in FY 2008.

A further reason that VA has underestimated the need for medical services is that they continue to use the same formula that they use for CARES, which is a civilian-based model. Mr. Chairman, VVA has testified many times that the VHA must be a "veterans' health care system" and not a general health care system that happens to see veterans if the VHA is to properly and adequately address the needs of veterans, particularly veterans who are sick or injured in military service. The model VA uses was designed for middle-class people who can afford HMOs or other such programs. It projects only one to three "presentations" (things wrong with) patients as opposed to the five to seven that is the average at VHA for veterans. Obviously, one using the VA model will continually underestimate overall resources needed to care for the veterans who come to the system by using this civilian formula. Fur-

ther, VHA has been consistent in underestimating the number of GWOT returnees who will seek services from the system in each of the last 4 years. VVA has corrected these errors in our projections.

In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional billion dollars to assist VA in meeting the long-term care and mental health care needs of all veterans. These funds should be used to develop or augment with permanent staff at VA Vet Centers (Readjustment Counseling Service, or RCS), as well as PTSD teams and substance use disorder programs at VA Medical Centers and CBOCs, which will be sought after as more troops (including demobilized National Guard members and Reservists) return from ongoing deployments. In addition, VA should be augmenting its nursing home beds and community resources for long-term care, particularly at the State veterans' homes.

To assist in developing these programs and augmenting all areas of veterans' care, VVA recommends funding to accommodate the staff-to-patient ratio VA had in place before VA had dismantled so much of its neuro-psychiatric and long-term care infrastructure. This would allow VA to better ensure timely access to care and services. Studies have shown that inadequate staffing—particularly of nurses involved in direct care—is correlated with poorer health care outcomes in all medical disciplines. To allow the staffing ratios that prevailed in 1998 for its current user population, VA would have to add more than 20,000 direct-care employees—MDs and nurses—at a cost of about $2.2 billion.

The $2.2 billion funding for the staff shortfalls identified by VVA closely corresponds to the funding from unspecified "management efficiencies" VA has had to shoulder throughout this Administration. It is important to realize that the effect of leaving these funding deficiencies unfulfilled is cumulative. That is, each year VA is forced to live with a greater hole in its budget. GAO has joined VSOs and Congress in questioning the extent to which VA has been able to identify and realize the so-called savings created by such proposed efficiencies. VA officials have advised GAO that the efficiencies identified in at least two recent budget proposals—FY 2003 and FY 2004—were developed to allow VA to meet its budget guidance rather than by detailed plans for achieving such savings (GAO–06–359R). In other words, the savings were justified only by the need to meet the Administration's "bottom line." I hope Congress agrees that this is no way to fund our veterans' health care system.

Finally, VVA believes Congress did a grave injustice to Vietnam-era veterans. For decades, veterans exposed to Agent Orange and other herbicides containing dioxin had been granted health care for conditions that were presumed to be due to this exposure. This special eligibility expired at the end of 2005 and, despite our request, Congress did not reauthorize it. Had Congress simply reauthorized existing authority, VA would have realized no new costs. Now we have heard that the Congressional Budget Office estimates that it will cost more than $300 million to restore this eligibility. Why this eligibility was allowed to expire seems more a matter of dollars than sense to VVA, given the ever-mounting body of research that clearly points to conditions such as diabetes being linked to dioxin exposure. However, the pressing issue now is to reinstate veterans with these conditions for the higher priority access to services that they deserve.

MEDICAL FACILITIES

For medical facilities for Fiscal Year 2008, VVA recommends $5.1 billion. This is approximately $1.5 billion more than the Administration's request for Fiscal Year 2008. Maintenance of the health care system's infrastructure and equipment purchases are often overlooked as Congress and the Administration attempt to correct more glaring problems with patient care. In FY 2006, in just one example, within its medical facilities account VA anticipated spending $145 million on equipment, yet only spent about $81 million. (The rest of the funds went just to meet costs to keep the facilities open and operating.) However, these projects can only be neglected for so long before they compromise patient care, and employee safety in addition to risking the loss of outside accreditation. The remainder of the funding was apparently shifted to other more immediate priority areas (i.e., keeping facilities operating in the short run).

VA undertook an intensive process known as CARES (Capital Asset Realignment to Enhance Services) to "right-size" its infrastructure, culminating in a May 2004 policy decision that identified approximately $6 billion in construction projects. While for the reasons noted above the VA has consistently underestimated future needs by using a fatally flawed formula, thus far Congress and the Administration have only committed $3.7 billion of this all too conservative needed funding.

We believe the CARES estimate to be extremely conservative given that the models projecting health care utilization for most services were based on use patterns in generally healthy managed care populations rather than veterans and that the patient population base did not include readmitting Priority 8 veterans, or significant casualties from the current deployments. Notwithstanding our concerns about the methods used in CARES, very few of the projects VA agrees are needed have been funded since this time. Non-recurring maintenance and capital equipment budgets have also been grievously neglected as administrators have sought to shore up their operating funds.

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60 percent of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts with a minimum of remaining $2.3 billion.

MEDICAL AND PROSTHETIC

Research For medical and prosthetic research for Fiscal Year 2008, VVA recommends $460 million. This is approximately $50 million more than the Administration's request for Fiscal Year 2008. VA research has a long and distinguished portfolio as an integral part of the veterans' health care system. Its funding serves as a means to attract top medical schools into valued affiliations and allows VA to attract distinguished academics to its direct-care and teaching missions.

VA's research program is distinct from that of the National Institutes of Health because it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing environmental hazard exposures, post-deployment mental health, traumatic brain injury, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

Further, VVA brings to your attention that VA Medical and Prosthetic Research is not currently funding a single study on Agent Orange or other herbicides used in Vietnam, despite the fact that more than 300,000 veterans are now service-connected disabled as a direct result of such exposure in that war. VVA submits that this is unacceptable.

Mr. Chairman, finally I urge this Committee to at long last urge your colleagues on the Appropriations Committee to use the power of the purse to compel VA to obey the law (Public Law 106–419) and conduct the long-delayed National Vietnam Veterans Longitudinal Study. VVA ask that you specifically request report language in the Appropriations bill for Military Construction, Veterans Affairs, and Related Agencies that compels VA to advise the Appropriators and the Authorizers as to how VA plans to complete this study properly within 2 years, as a comprehensive mortality and morbidity study.

ASSURED FUNDING FOR VETERANS' HEALTH CARE

Once this Congress provides a budget that shores up VA medical services and facilities, it will need to assure that VA continues to be funded at a level that allows it to provide high-quality health care services to the veterans that need them. That is where enactment of assured funding will come in. Once enacted, an assured funding mechanism will ensure that, at a minimum, annual appropriations cover the cost of inflation and growth in the number of veterans using VA health care. It will allow VA administrators some predictability in both how much funding it will receive and when it will be received, resulting in higher quality and ultimately more cost-effective care for our veterans.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) is in even more acute need of additional resources and enhanced accountability measures now than it was a year ago. VVA recommends an additional 400 over and above the roughly 470 new staff members that are requested in the President's proposed budget for all of VBA.

COMPENSATION & PENSION

VVA recommends adding one hundred staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional

$60 million specifically earmarked for additional training for all of those who touch a veteran's claim, institution of a competency-based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and state employees, and any others who might presume to at any point touch a veteran's claim.

VOCATIONAL REHABILITATION

VVA recommends that you seek to add an additional 300 specially trained vocational rehabilitation specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. It is clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much greater accountability to the VA Vocational Rehabilitation process is absolutely essential if we as a Nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

ACCOUNTABILITY AT VA

So much of what VVA and the Congress on both sides of the aisle find wrong or disturbing at the VA revolves around the general and all-pervasive issue of little or no accountability, or imprecise fixing of authority commensurate with accountability mechanisms that are meaningful (and vice versa) in all parts of the VA.

Within the past year, VA has finally made significant progress in meeting the minimum goal of at least 3 percent of all contracts and 3 percent of all subcontracts being let to service-disabled veteran business owners. Secretary Nicholson and Deputy Secretary Mansfield are to be commended on setting the pace for the Federal Government. It is instructive in this discussion, however, that the action directed by the Secretary to put achievement or substantial real progress toward meeting or exceeding the 3 percent minimum into the performance evaluation of each Director of the 21 Veterans Integrated Service Networks (VISNs) was a key element enabling VA to be the first large agency to reach the goal mandated by law. Some 85 percent of all VA procurement is through VHA, primarily through the VISNs is the key factor in this achievement.

All people (particularly people with a great deal of responsibility who work long hours) care about what they feel they have to care about. Putting it in the performance evaluations means that those managers who ignore a requirement do not get an outstanding or superior rating, and hence no bonus. VVA, and now the VA in at least this one instance, has always found that it is amazing how reasonable almost all people can be when you have their full attention.

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It can be cleaned up and done right the first time, it there is the political will to hold people accountable for doing their job properly.

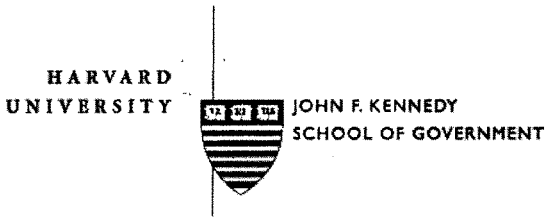
Lastly, there is no excuse for the continuation of the practice of VHA to "lose" tens of millions (sometimes hundreds of millions) of taxpayer dollars that are appropriated to VHA for specific purposes, whether that purpose be to restore organizational capacity to deliver mental health services, particularly for PTSD and other combat trauma wounds, or to conduct outreach to GWOT veterans as well as demobilized National Guard and Reserve returnees from war zone deployments. There is a consistent pattern of VA, particularly VHA, to either really not know what happened to large sums of money given to them for specific reasons, or they are not telling the truth to the Congress and the public. In either case, it is unacceptable and cannot be tolerated any longer.

In the proposed budget submittal, VVA struggled with accounting for the dollars footnoted in the President's submittal as "Adjusted for IT." We could not find an accurate accounting. When we asked, it turns out that no one that we have spoken to, including VA officials, can fully explain at least $200 million-plus of this "adjustment" either. And this is before they get their hands on the dollars. VVA urges this Committee and your colleagues on Appropriations to make this the year that this sloppy nonsense and dissembling is stopped once and for all. Accountability will only come about when Congress absolutely demands that these folks be fully accountable for performance, and for accounting for each and every taxpayer dollar.

Thank you again, Mr. Chairman. We look forward to working with you and this distinguished Committee to obtain an excellent budget for VA in FY 2008, and to

ensure the next generation of veterans' well-being by enacting assured funding. I will be happy to answer any questions you and your colleagues may have.

[The working paper prepared by Linda Bilmes of the John F. Kennedy School of Government, Harvard University, follows:]



Faculty Research Working Papers Series

Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits

Linda Bilmes
John F. Kennedy School of Government - Harvard University

January 2007

RWP07-001

SOLDIERS RETURNING FROM IRAQ AND AFGHANISTAN: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits

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EXECUTIVE SUMMARY:

This paper analyzes the long-term needs of veterans returning from the Iraq and Afghanistan conflicts, and the budgetary and structural consequences of these needs. The paper uses data from government sources, such as the Veterans Benefit Administration Annual Report. The main conclusions of the analysis are that:

(a) the Veterans Health Administration (VHA) is already overwhelmed by the volume of returning veterans and the seriousness of their health care needs, and it will not be able to provide a high quality of care in a timely fashion to the large wave of returning war veterans without greater funding and increased capacity in areas such as psychiatric care;

(b) the Veterans Benefits Administration (VBA) is in need of structural reforms in order to deal with the high volume of pending claims; the current claims process is unable to handle even the current volume and completely inadequate to cope with the high demand of returning war veterans; and

(c) the budgetary costs of providing disability compensation benefits and medical care to the veterans from Iraq and Afghanistan over the course of their lives will be from $350 - $700 Billion, depending on the length of deployment of US soldiers, the speed with which they claim disability benefits and the growth rate of benefits and health care inflation.

Key recommendations include: increase staffing and funding for veterans medical care particularly for mental health treatment; expand staffing and funding for the "Vet Centers," and restructure the benefits claim process at the Veterans Benefit Administration.

This paper was prepared for the Allied Social Sciences Association Meetings in Chicago, January, 2007. The views expressed here are solely those of the author and do not represent any of the institutions with which she is affiliated, now or in the past.

Introduction

The New Year has brought with it the grim fact that 3000 American soldiers have been killed so far in Iraq. A statistic that merits equal attention is the unprecedented number of US soldiers who have been injured. As of September 30, 2006, more than 50,500 US soldiers have suffered non-mortal wounds in Iraq, Afghanistan and nearby staging locations – a ratio of 16 wounded servicemen for every fatality[1]. This is by far the highest killed-to-wounded ratio in US history. For example, in the Vietnam and Korean wars there were 2.6 and 2.8 injuries per fatality, respectively. World Wars I and II had fewer than 2 wounded servicemen per death[2].

While it is welcome news and a credit to military medicine that more soldiers are surviving grievous wounds, the existence of so many veterans, with such a high level of injuries, is yet another aspect of this war for which the Pentagon and the Administration failed to plan, prepare and budget. There are significant costs and requirements in caring for our wounded veterans, including medical treatment and long-term health care, the payment of disability compensation, pensions and other benefits, reintegration assistance and counseling, and providing the statistical documentation necessary to move veterans seamlessly from the Department of Defense payroll into Department of Veterans Affairs medical care, and to process VA disability claims easily.

To date, 1.4 million US servicemen have been deployed to the Global War on Terror (GWOT), the Pentagon's name for operations in and around Iraq and Afghanistan[3]. The servicemen who have been officially wounded are a small percentage of the veterans who will be using the veteran's administration medical system. Hundreds of thousands of these men and women will be seeking medical care and claiming disability compensation for a wide variety of disabilities that they incurred during their tours of duty[4]. The cost of

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[1] Department of Veterans Affairs, Office of Public Affairs, "America's Wars", September 30, 2006. This document shows that the number of non-mortal woundings in the Global War on Terror (combining Iraq, Afghanistan and surrounding duty stations) as of 9/30/06 was 50,508 compared with 2333 deaths in battle plus 707 other deaths in theater. The comparison numbers for previous conflicts are as follows: Desert Storm/Desert Shield: 1.2 wounded per fatality; Vietnam: 2.6 wounded per fatality; Korea: 2.8 wounded per fatality; World War II: 1.6 wounded per fatality; World War I: 1.8 wounded per fatality; Civil War (union): .7 wounded per fatality; War of 1812: .5 wounded per fatality; American Revolution: .7 wounded per fatality. Note: the VA defines non-mortal wounded as those who are "medically evacuated from theatre". The Pentagon has several definitions, but the daily casualty reports on its website use a narrower definition referring to those wounded by shrapnel, bullets, etc. Using this narrow definition, the Iraq conflict has a ratio of 8 wounded per fatality – still much higher than any previous war in US history.

[2] Ibid.

[3] As of September 30, 2006, 1,406,281 unique service members have been deployed to the wars in Iraq and Afghanistan, according to the Department of Defense, Defense Manpower Data Center, and "Contingency Tracking System." The Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, November 2006 uses the number 1.4 million (as of November 2006). The Veterans Benefits Administration (VBA) lists 1,324,419 unique servicemen deployed to GWOT as of May 2006 (prepared by VBA/OPA&I, 7/20/06).

[4] Based on an analysis of the first Gulf War in 1991, using the Gulf War Veterans Information System (GWVIS August 2006, chart on "Gulf War Veteran Outpatient Stays)), there were 297,125 veterans from that conflict who used VA medical care, or 48.4%. If the same percentages of Iraq/Afghan veterans use VA medical care then VA should expect approximately 700,000 new patients from the 1.4 million existing

providing such care and paying disability compensation is a significant long-term entitlement cost that the US will be paying for the next forty years[5].

The objective of this paper is to examine the structural and budgetary requirements for caring for the returning war veterans from Iraq and Afghanistan, in terms of US capacity to pay disability compensation, provide high quality medical care, and provide other essential benefits. The paper grew out of a previous paper that was co-authored in January 2005 with Columbia University professor Joseph Stiglitz, in which the overall costs of the war in Iraq were estimated to exceed $2 trillion. One of the long-term costs cited in that paper was the cost associated with providing health care and disability benefits to veterans[6]. This paper expands on that topic.

Unlike the previous paper[7], this study does not differentiate between veterans returning from Iraq, or Afghanistan or adjacent locations (such as Kuwait, an important staging post for Iraq) in the GWOT, for three reasons. First, nearly one-third of the servicemen involved in the war have been deployed two or more times and many of them have served both in Iraq and Afghanistan, and/or other locations[8]. Second, the data available from the VA does not distinguish between the wars in Iraq and Afghanistan. Third, for the purposes of estimating the long-term costs of taking care of the returning veterans it does not matter where they served. However it is worth noting that the overwhelming majority of the deaths and injuries incurred in the GWOT have been in Iraq. Among those listed as wounded on the Pentagon's casualty reports, more than 95% have been injured in Iraq[9].

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servicemen. Increasing the number of unique servicemen deployed will increase medical and disability usage.

[5] Veterans' disability pay is an entitlement program, like Medicare and Social Security. Once a veteran has been approved to receive disability pay, he or she is entitled to receive an annual payment and cost-of-living adjustments. The average age of a servicemen is about 25 years of age, therefore given current life expectancy rates, 40 years is a reasonable amount of years to project payment of benefits, even assuming the veteran does not claim for some years following the period of service.

[6] Bilmes, Linda and Stiglitz, Joseph, *The Economic Costs of the Iraq War: An Appraisal Three Years After the Beginning of the Conflict,* NBER Working Paper 12054 (http://www.nber.org/papers/w12054), February 2006. The long-term budgetary costs associated with veterans health and disability cited in that paper ranged from $77bn to $179bn (depending on the length of the war), based on a population of 550,000 unique Iraqi war veterans. After we published this paper, a number of veteran's organizations including the American Legion and Veterans for America, contacted us in appreciation of our highlighting the needs of veterans. Veterans for America has particularly encouraged further research to understand the needs of the returning GWOT veteran's community.

[7] The Bilmes/Stiglitz cost of war paper did not include the costs of Afghanistan or other areas outside of Iraq in the GWOT. Had we included those costs, the total cost of war would have increased by 15-20%.

[8] As of 9/30/06, some 421,206 (30%) of 1,406,281 unique service members had been deployed twice or more to the wars in Iraq and Afghanistan. Army Times, December 11, 2006, page 14, from the Department of Defense, Defense Manpower Data Center, "Contingency Tracking System."

[9] As of 12/28/06, the DOD website listed 22,565 wounded in Operation Iraqi Freedom and 1084 wounded in Operating Enduring Freedom (Afghanistan). As noted previously, this is a narrower definition of injuries than the one used by the Veterans administration, which lists 50,508 non-mortal woundings as of 9/30/06.

This paper will analyze the following aspects of the returning veterans' needs.

1. Disability compensation
    - Projected Cost
    - Backlog of Pending Claims
2. Medical care
    - Capacity issues
    - Projected Cost
    - Veterans Centers
    - Transitioning from the Department of Defense to VA care
3. Overall assessment of US readiness to meet its obligations to veterans
4. Recommendations

Methodology

All statistics used in this paper are from government sources, including publications of the Veterans Benefit Administration (VBA), Veterans Health Administration (VHA), and other VA offices, as well as from the Congressional Budget Office, the Government Accountability Office, the Department of Defense, and Congressional testimony. The numbers are based on the servicemen involved in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, Afghanistan) unless otherwise noted.

The cost and structural requirements for returning veterans will depend on several factors, including the number of US troops stationed in the region and how long they are deployed; the rate of claims and utilization of health resources by returning troops, and the rate of increase in disability payment and health care costs over time. The model developed allows the user to vary these assumptions and may be obtained with permission from the author's website. The current analysis has been performed under three "base" scenarios that reflect, broadly the three options now under consideration for the war.

- Low Scenario: The low scenario assumes that the US begins withdrawing troops in 2007 and that all US servicemen are home by 2010. This pattern is roughly in parallel with the recommendations of the bipartisan Baker Commission that reported to President Bush in November 2006. This scenario assumes that *we will not deploy any new troops beyond the 1.4 million already participating in the war*. It assumes that 44% of US troops will claim for disability payment over a period of years, with 87% of claims granted, following the same claims pattern as the first Gulf War in 1991[10]. The low scenario assumes that soldiers will initially receive the VA's 2005 average recurring benefit and that the annual rate of

[10] Using the claims patterns from Gulf War I is almost certainly too conservative because that war was much shorter and relied primarily on aerial bombardment, whereas the current wars involve long deployments and ground warfare. However it provides a baseline for the current Iraq/Afghan wars.

increase will be 2.8% to reflect a cost-of-living adjustment only. (As opposed to the actual growth rate over the past 10 years which is 6.1%). The medical usage in this scenario is based on the lowest possible uptake of medical care and a rate of increase that is below the historical rate of health care inflation. In short, this scenario shows the absolute basement level -- the lowest possible cost of providing medical care and disability benefits to soldiers returning from Iraq and Afghanistan under the most optimistic assumptions.

- Moderate Scenario: The moderate scenario is based on the current course of the war. This scenario uses the Congressional Budget Office's expected deployment figures, which would involve a gradual drawdown of troops but maintain a small US force in the region through 2015. Under this scenario, the total unique servicemen involved in the conflict will be 1.7 million, that is, 300,000 additional troops rotated in over the period of years. Nearly 20,000 new troops are regularly deployed into the two war zones each month, before any "surge" or escalation of the conflict is considered [11](This scenario uses the first Gulf War as the basis for predicting the level of troops who will claim disability benefits, the rate of approval of the claims, and the utilization of medical resources. However a growth rate of 4.4% is projected for claims benefits, half way between the base cost-of-living adjustment and the actual growth rate of 6.1%.

- High "Surge" Scenario: This scenario assumes that troop levels with surge in 2007 and that the total participation in the war over time will eventually reach 2 million unique servicemen by 2016. It also models the potential that half the veterans claim disability payments, which is a reasonable possibility given the ferocity of the conflict and the number of second and third deployments. This model also looks at the impact of growth in claims benefit payments and health care costs based on the actual growth rates over the past ten years. If the US decides to increase troops and all trends on disability and health care continue as they have in the past, this model presents the resulting cost consequences.

The costs estimated in this study are budgetary costs to the US government directly associated with the payment of disability benefits and medical treatment for returning OIF/OEF war veterans. The costs do not include the interest payments on the debt that is being incurred in borrowing money to finance the war. Future cash flows were discounted at a rate of 4.75% reflecting current long-term US borrowing rates.

1. Disability Compensation

There are 24 million living veterans, of whom roughly 11% receive disability benefits. Overall, in 2005 the US currently paid $23.4 billion in annual disability entitlement pay

[11] Footnote: Analysis of DMDC's Contingency Tracking System shows 57,462 new first-time deployments between June 2006 and September 2006, an average 19,154 per month

to veterans from previous wars, including 611,729 from the first Gulf War, 916,220 from Vietnam, 161,512 Korean War veterans, 356,190 World War II veterans and 3 veterans of World War I.[12]

All 1.4 million servicemen deployed in the current war effort are potentially eligible to claim some level of disability compensation from the Veterans Benefits Administration. Disability compensation is a monetary benefit paid to veterans with "service-connected disabilities" -- meaning that the disability was the result of an illness, disease or injury incurred or aggravated while the soldier was on active military service. Veterans are not required to seek employment nor are there any other conditions attached to the program. The explicit congressional intent in providing this benefit is "to compensate for a reduction in quality of life due to service-connected disability" and to "provide compensation for average impairment in earnings capacity." The principle dates back to the Bible at Exodus 21:25, which authorizes financial compensation for pain inflicted by another[13].

Disability compensation is graduated according to the degree of the veteran's disability, on a scale from 0 percent to 100 percent, in increments of 10%. Annual benefits range from a low of $1304 per year for a veteran with a 10% disability rating to about $44,000 in annual benefits for those who are completely disabled[14]. The average benefit is $8890 although this varies considerably; Vietnam veterans average about $11,670[15]. Additional benefits and pensions are payable to veterans with severe disabilities. Once deemed eligible, the veteran receives the compensation payment as a mandatory entitlement for the remainder of their lives, like Medicare and Social Security.

There is no statute of limitations on the amount of time a veteran can claim for most disability benefits. The majority of veteran's claims are within the first few years after returning, but some disabilities do not surface until years later. The VA is still handling hundreds of thousands of new claims from Vietnam era veterans for post-traumatic stress disorder and cancers linked to Agent Orange exposure.

The process for ascertaining whether a veteran is suffering from a disability, and determining the percentage level of a veteran's disability, is complicated and lengthy. A veteran must apply to one of the 57 regional offices of the Veterans Benefits Administration (VBA), where a claims adjudicator evaluates the veteran's service-connected impairments and assigns a rating for the degree to which the veteran is disabled. For veterans with multiple disabilities, the regional office combines the ratings into a single composite rating. If a veteran disagrees with the regional office's decision he or she can file an appeal to the VA's Board of Veterans Appeals. The Board makes a final decision and can grant or deny benefits or send the case back to the regional office

[12] Ibid, page 33, "Benefits delivery network", RCS 20-0221

[13] See Veterans Benefits Administration "Annual Benefits Report" (ABR), 2005, page 17 for definition of disability compensation and see VA Disability Compensation Program, *Legislative History*, VA Office of Policy, Planning and Preparedness 2004 for principles behind the program.

[14] Ibid, page 24, lists $1304 for 10% and $31,611 for 100%, but those with 100% disability also receive additional payments that combined result in an annual payment of approximately $44,000.

[15] Ibid, page 33.

for further evaluation. Typically a veteran applies for disability in more than one category, for example, a mental health condition as well as a skin disorder. In such cases, VBA can decide to approve only part of the claim – which often results in the veteran appealing the decision. If the veteran is still dissatisfied with the Board's decision to grant service connection or the percentage rating, he or she can further appeal it to two even higher levels of decision-makers.[16]

Most employees at VA are themselves veterans, and are predisposed to assisting veterans obtain the maximum amount of benefits to which they are entitled. However, the process itself is long, cumbersome, inefficient and paperwork-intensive. The process for approving claims has been the subject of numerous GAO studies and investigations over the years. Even in 2000, before the current war, GAO identified longstanding problems in the claims processing area. These included large backlogs of pending claims, lengthy processing times for initial claims, high error rates in claims processing, and inconsistency across regional offices[17]. In a 2005 study, GAO found that the time to complete a veteran's claim varied from 99 days at the Salt Lake City regional office to 237 days at the Honolulu, Hawaii office[18].

The backlog of pending claims has been growing since 1996. In 2000, VBA had a backlog of 69,000 pending initial compensation claims, of which one-third had been pending for more than six months[19]. Today, due in part to the surge in claims from the Iraq/Afghan wars, VBA has a backlog of 400,000 claims[20]. VBA now takes an average of 177 days (six months) to process an original claim, and an average of 657 days (nearly two years) to process an appeal.[21] This compares unfavorably with the private sector health care/financial services industry, which processes an annual 30 billion claims in an average of 89.5 days per claim, *including* the time required for claims that are disputed[22].

Projected Demand for Benefits among OIF/OEF Veterans

It is difficult to predict with certainty the number of veterans from the two current wars who will claim for some amount of disability. The first Gulf War provides a baseline number although the Iraq and Afghanistan war has been longer and has involved more ground warfare than the Desert Storm conflict, which relied largely on aerial bombardment and four days of intense ground combat. However, in both conflicts, a

[16] GAO, "Veterans Benefits Administration: problems and Challenges Facing Disability Claims Processing", GAO Testimony before the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs, May 18, 2000
[17] Ibid.
[18] "Veterans Benefits: Further Changes in VBA's Field Office Structure could help improve disability claims processing", GAO-06-149, December 2005
[19] Ibid
[20] The VBA's backlog of pending claims was 399,751 as of December 9, 2006 (VBA Monday Morning Workload Report).
[21] The average time to process a claim is 177 days as of 9/06 and average time to process an appeal is 657 days (VA Performance and Accountability Report FY 2006).
[22] Bearing Point, Health Care/Financial Services industry report, September 14, 2006.

number of veterans were exposed to depleted uranium that was used in anti-tank rounds fired by US M1 tanks and US A10 attack aircraft. Many disability claims from the first Gulf War stem from exposure to depleted uranium, which has been implicated in raising the risk of cancers and birth defects. Gulf War veterans also filed disability claims related to exposures to oil well fire pollution, low-levels of chemical warfare agents, experimental anthrax vaccines, and experimental anti-chemical warfare agent pills called pyridostigmine bromide, the anti-malaria pill Lariam, skin diseases, and disorders from living in the hot climate[23], which are likely to be cited in the current conflict. However, the number of disability claims in the Iraq/Afghan wars is likely to be higher due to the significantly longer length of soldier's deployments, repeat deployments, and heavier exposure to urban combat.

Following the Gulf War the criteria for receiving benefits were widened by Congress based on evidence of widespread toxic exposures[24]. The same criteria for healthcare and benefits eligibility still apply to veterans of the Iraq and Afghanistan wars[25]. Forty-four percent of those veterans filed disability claims for a variety of conditions and 87% were approved[26]. The US currently pays about $4 billion annually in disability payments to veterans of Desert Storm/Desert Shield[27].

Of the 1.4 million US servicemen who have so far been deployed in the Iraq/Afghan conflicts, 631,174 have been discharged as of September 30, 2006. Of those 46% are in the full-time military and 54% are reservists and National Guardsmen.[28] Therefore the total population that is potentially eligible for disability benefits is this number (631,174). To date 152, 669 servicemen have applied for disability benefits and of those, 104,819 have been granted, 34,405 are pending and 13,445 have been rejected. This implies an approval rate of 88% to date.[29]

We have estimated the cost of providing disability benefits to veterans under three scenarios. Under the low scenario, we expect that as in the first Gulf War, 44% of the current veterans will eventually claim disability, with an approval rate of 87%. We estimate that the remaining 900,000 troops will be discharged in equal installments over the next 4 years bringing all US troops home by 2010. We expect the same percentage of these troops to claim for disabilities, with the same approval rate, within a further 5 years.

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[23] Veterans for America, interview with Paul Sullivan, program director, 11/06.

[24] "Veterans Benefits Improvement Act of 1994" (Public Law 103-446) and "Persian Gulf War Veterans Act of 1998 (PL 105-277).

[25] In fact, the VA does not distinguish, for the purpose of claims processing, between the end of the first Gulf War and the present conflict (38 USC Section 101(33) defines the Gulf War as starting on August 2, 1990, and continuing until either the President or the Congress declares an end to it and 38 CFR 3.317 defines the locations of the conflict).

[26] For Gulf War, the total claims filed to date are 271,192, of which 205,911 have been approved, 20,382 were denied and 34,899 are still pending (GWVIS, August 2006, p.7: Granted Service Connection +Denied Service Connection +Claims Pending)

[27] Gulf War total annual payment $4.3 billion (Ibid., VBA, ABR 2005 pp. 33)

[28] VHA, Office of Public Health and Environmental Hazards, November 2006

[29] VBA "Compensation and Benefit Activity among veterans deployed to the GWOT", July 20, 2006, obtained under Freedom of Information Act by the National Security Archive at George Washington University.

We have assumed that on average, claims are lower than average rate, at the lower rate of new claimants from the first Gulf War of $6506[30]. This is probably an excessively conservative assumption because it projects the same rate of serious injuries as occurred in Gulf War I, when in fact we already know that more than the actual rate of serious injuries is much higher[31].

The moderate scenario assumes that the war continues through 2014 with a total deployment of 1.7 million over the course of the war, and with gradually reduced deployment. It assumes that a slightly higher percentage of eligible veterans (50%) make claims, which is more realistic given deployment lengths. This scenario uses the actual average VA benefit payment of $8890. It assumes the rate of increase in benefits is 4.4%, midway between the mandatory Cost of Living Adjustment and the actual ten-year growth rate of 6.1%. The high scenario models the impact of a surge in forces bringing the total unique deployments to 2 million. It assumes 50% of eligible forces claim benefits and a rate of 6.1% increase, which is the actual rate over the past 10 years. It further assumes a higher rate of medical inflation (10% vs. 8% in the low and moderate scenarios).

Table 1: Long-term Cost of Veterans Disability Benefits[32]

scenario	Low	Moderate	High
Disability Benefits ($bn)	67.63	109.98	126.76

Backlog of Pending Disability Claims

The issue is not simply cost but also efficiency in providing disabled veterans with their benefits. In addition to all the problems detailed above, the Iraq and Afghan war veterans are filing claims of unusually high complexity (see table 3). To date, the backlog of pending claims from these recent war veterans is 34,000, but the vast majority of servicemen from this conflict have not yet filed their claims. Even without the projected wave of claims, the VA has an overall backlog of 400,000, including thousands of Vietnam era claims. Including all pending claims and other paperwork, the VA's backlog has increased from 465,623 in 2004 to 525,270 in 2005 to 604,380 in 2006.[33]

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[30] Ibid, ABR 2005, p33

[31] Of the 50,508 non-mortally wounded soldiers in OIF/OEF there are at least 10,000 serious injuries such as brain injuries, spinal and amputations, according to DOD sources. See also Wallsten and Kosec, AEI-Brookings Working Paper 05-19, September 2005, estimate of 20% serious brain injuries, 6% amputees and 24% other serious injuries.

[32] The figures in Table 1 represent the present value of disability benefits over 40 years for eligible veterans projected under the three scenarios described.

[33] VBA's "Monday Morning Report" of pending claims and other work performed at regional offices, cites: 11/25/06: 604,380; 11/26/05: 525,270; 11/27/04: 465,623.

The fact that the VBA is largely sympathetic to the plight of disabled veterans should not obscure the fact that this system is already under tremendous strain. If only one fifth of the returning veterans who are eligible claim in a given year, and the total claims reaches a high of 38% effective rate (44%* 88% approval rate), the number of likely claims at the VBA over the next ten years can be expected to rise from 104,819 to more than 600,000[34]. (See table 2).

Table 2: Projected Increase in Disability Claims (moderate scenario)

	2006	2007	2008	2009	2010	2011	2012
Disability Benefits							
Discharged		118,758	118,758	118,758	118,758	118,758	118,758
cum		*118,758*	*237,517*	*356,275*	*475,034*	*593,792*	*712,551*
Eligible claimaints							
Existing discharged non-claimants	526,355	526,355	526,355	526,355	526,355	526,355	526,355
Newly discharged	-	118,758	237,517	356,275	475,034	593,792	712,551
Total potential claimants		645,113	763,872	882,630	1,001,389	1,120,147	1,238,906
Claim rate	22%	22%	27%	33%	38%	44%	44%
New claims	-	140,312	207,678	287,958	381,154	487,264	538,924
Current beneficiaries	104,819	104,819	104,819	104,819	104,819	104,819	104,819
Total claims (number)	104,819	245,131	312,497	392,777	485,973	592,083	643,743
Total claims ($bn)	**0.93**	**2.27**	**2.89**	**3.63**	**4.49**	**5.47**	**5.95**

If nothing is done to address the problem, the claims backlog will continue to grow throughout the period of the war, along with growing inequity between different regional offices. A key question is: what is a reasonable amount of time for the US to make a disabled veteran wait for a disability check? This paper proposes several actions that could reduce the length of time for processing from zero to 90 days. (Described in more detail in Section 4: Recommendations). These include: (a) greater use of the "Vet Centers" to provide assistance for veterans to file their claims, (b) automatically granting all or some of the claims, with subsequent audits to deter fraud, and (c) streamlining and technologically upgrading the claims system into a "fast track" where veterans receive a quick decision on most claims.

2. Veterans Medical Care Shortfall

The VA's Veterans Health Administration provides medical care to more than 5 million veterans each year. This care includes primary and secondary care, as well as dental, eye and mental health care, hospital inpatient and outpatient services. The care is free to all returning veterans for the first two years after they return from active duty; thereafter the VA imposes co-payments for various services, with the amounts related to the level of disability of the veteran[35].

[34] This projection based on the moderate scenario described previously, based on 1.7 million unique servicemen and CBO troop deployment figures through 2014.
[35] 38 USC Section 1710

The VA has long prided itself on the excellence of care that it provides to veterans. In particular, VA hospitals and clinics are known to perform a heroic job in areas such rehabilitation. Medical staff is experienced in working with veterans and provides a sympathetic and supportive environment for those who are disabled. It is therefore of utmost important that the quality of care be maintained as the demand for it goes up.

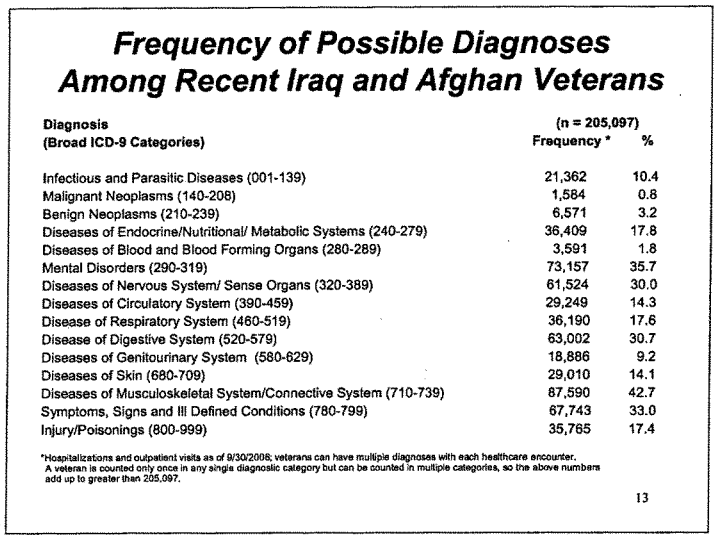
However, the demand for VA medical treatment is far exceeding what the VA had anticipated. This has produced long waiting lists and in some cases simply the absence of care. To date, 205,097, or 32% of the 631,174 eligible discharged OEF/OIF veterans have sought treatment at VA health facilities. These include 35% of the eligible active duty servicemen (101,260) and 31% of the eligible Reservists/Guards (103,837). To date, this number represents only 4% of the total patient visits at VA facilities – but it will grow. According to the VA, "As in other cohorts of military veterans, the percentage of OIF/OEF veterans receiving medical care from the VA and the percentage of veterans with any type of diagnosis will tend to increase over time as these veterans continue to enroll for VA health care and to develop new health problems"[36].

The war in Iraq has been noteworthy for the types of injuries sustained by the soldiers. Some 20% have suffered brain trauma, spinal injuries or amputations; another 20% have suffered other major injuries such as amputations, blindness, partial blindness or deafness, and serious burns.

However, the largest unmet need is in the area of mental health care. The strain of extended deployments, the stop-loss policy, stressful ground warfare and uncertainty regarding discharge and leave has taken an especially high toll on soldiers. Thirty-six percent of the veterans treated so far -- an unprecedented number -- have been diagnosed with a mental health condition. These include PTSD, acute depression, substance abuse and other conditions. According to Paul Sullivan, a leading veterans advocate, "The signature wounds from the wars will be (1) traumatic brain injury, (2) post-traumatic stress disorder, (3) amputations and (4) spinal chord injuries, and PTSD will be the most controversial and most expensive" [37] (see Table 3)

Table 3: VHA Office of Public Health, November 2006

[36] VHA, Office of Public Health and Environmental Hazards, November 2006, Ibid, p. 14
[37] Paul Sullivan, Program Director of Veterans for America, 12/23/06 interview



Frequency of Possible Diagnoses Among Recent Iraq and Afghan Veterans

Diagnosis (Broad ICD-9 Categories)	(n = 205,097) Frequency *	%
Infectious and Parasitic Diseases (001-139)	21,362	10.4
Malignant Neoplasms (140-208)	1,584	0.8
Benign Neoplasms (210-239)	6,571	3.2
Diseases of Endocrine/Nutritional/ Metabolic Systems (240-279)	36,409	17.8
Diseases of Blood and Blood Forming Organs (280-289)	3,591	1.8
Mental Disorders (290-319)	73,157	35.7
Diseases of Nervous System/ Sense Organs (320-389)	61,524	30.0
Diseases of Circulatory System (390-459)	29,249	14.3
Disease of Respiratory System (460-519)	36,190	17.6
Disease of Digestive System (520-579)	63,002	30.7
Diseases of Genitourinary System (580-629)	18,886	9.2
Diseases of Skin (680-709)	29,010	14.1
Diseases of Musculoskeletal System/Connective System (710-739)	87,590	42.7
Symptoms, Signs and Ill Defined Conditions (780-799)	67,743	33.0
Injury/Poisonings (800-999)	35,765	17.4

*Hospitalizations and outpatient visits as of 9/30/2006; veterans can have multiple diagnoses with each healthcare encounter. A veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 205,097.

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Additionally, far more returning Iraqi war veterans (than those in previous conflicts) are likely to seek such help, in part due to awareness campaigns run by veteran's organizations through the press. There is no reliable data on the length of waiting lists for returning veterans, but even the VA concedes that they are so long as to effectively deny treatment to a number of veterans. In the May 2006 edition of Psychiatric News, Frances Murphy M.D., the Under Secretary for Health Policy Coordination at VA, said that mental health and substance abuse care are simply not accessible at some VA facilities. When the services are available, Dr. Murphy asserted that, "waiting lists render that care virtually inaccessible."[38]

The VA curiously maintains that it can cope with the surge in demand, despite much evidence to the contrary. For the past two years, the VA ran out of money to provide health care. In FY 2006, the VA was obliged to submit an emergency supplemental budget request for $2 billion, which included $677 million to cover an unexpected 2% increase in the number of patients (half of which were OIF/OEF patients), $600 million to correct its inaccurate estimate of long-term care costs, and $400 million to cover an unexpected 1.2% increase in the costs per patient due to medical inflation. The previous year, (FY 2005), VA requested an additional $1 billion, of which one-quarter was for unexpected OIF/OEF needs and remainder was related to overall under-estimation of patient costs, workload, waiting lists, and dependent care. The GAO analysis of these shortfalls concluded that they were due to the fact that VA was modeling its projections based on 2002 data, before the war in Iraq began[39].

[38] Frances Murphy, May 2006, *Psychiatric News*

[39] GAO-06-430R, "VA Health Care Budget Formulation", pp 18-20.

The budget shortfalls and the statement by Dr. Murphy suggest that the volume of veterans returning from Iraq and Afghanistan will not be able to obtain the health care they need, particularly for mental health conditions. Such veterans are at high risk for unemployment, homelessness, family violence, crime, alcoholism, and drug abuse, all of which impose an additional human and financial burden on the nation. In addition, many of these social services are provided by state and local governments which are already under tremendous strain.

Projected Medical Costs

The number of veterans who will eventually require treatment can be estimated using a baseline of the utilization during the first Gulf War, in which the VA is providing medical care to 48% of veterans. The average annual cost of treating veterans in the system is now $5000[40], although it is difficult to know whether the more grievous injuries and disabilities of the current conflict will drive up costs per patient.

The costs of providing medical care have been calculated under the three scenarios. Under the low scenario, under which the US will deploy no new troops, the ceiling for medical care is 48% of OIF/OEF veterans. If half of all veterans eventually seek medical treatment from the VA that will produce a demand of some 700,000 veterans. However, due to the fact that veterans are eligible for free care during the first two years after discharge, we can expect a wave of returning war veterans within two years of their discharge date. Additionally, since active duty veterans claim medical care at a higher rate (than Guards/Reservists) and have been deployed in more of the most hazardous front-line task come home, we can expect that the average cost of treating such veterans increases as well as a high level of demand[41].

If the demand for medical care increases as projected to some 700,000 or more veterans, there is a serious risk that the VA, which is already overwhelmed, will be unable to meet the medical needs of returning OIF/OEF veterans. Additional staff is needed in important areas such as brain trauma units and mental health. The VA also needs to expand systems such as triage nursing, to help leverage scarce medical resources.

Even assuming that no more troops are deployed, the long-term cost of treating returning veterans will reach $208 billion. This however assumes that the supply of health care exists to treat them. If the number of troops continues to grow as in the moderate then cost of providing lifetime care rises to $315 billion. The annual budget payment under this scenario will reach $3bn by 2010 and more than double by 2014. (See Table 4)

[40] This amount is calculated by estimating the budget 2006 supplemental budget request for OIF/OEF veterans per additional patient, using the GAO analysis in GAO-06-430R

[41] VHA, Office of Public Health and Environmental Hazards, Ibid.

Table 4: Projected Cost of for Providing VA Medical Care (moderate scenario)[42]

MEDICAL COSTS	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total Discharged	631,174	749,932	868,691	987,449	1,106,208	1,224,966	1,343,725	1,462,483	1,581,242
% OIF/OEF veterans seeking care	32.50%	33.96%	35.49%	37.09%	38.76%	40.50%	42.32%	44.23%	46.22%
Total OIF/OEF veterans seeking care	205,132	254,696	308,305	366,224	428,731	496,123	568,711	646,827	730,822
Cost/medical claim	$ 5,000	$ 5,400	$ 5,832	$ 6,299	$ 6,802	$ 7,347	$ 7,934	$ 8,569	$ 9,255
Total cost ($bn)	1.0	1.4	1.8	2.3	2.9	3.6	4.5	5.5	6.8
NPV	$ 315.23								

However, these scenarios are conservative in assuming that only half of the returning veterans will eventually seek medical treatment from the VA and that the level of health care inflation will remain constant at 8%. Under a worst-case scenario, if troops levels rise to 2 million and if health inflation rises to the double-digit levels experienced during the 1990s, we can expect the total cost of providing lifetime medical care to veterans to reach $600bn[43].

Veterans Centers

How can the VA possibly handle the number of returning troops who require care, as well as their families, especially for mental health conditions? Perhaps the most creative and successful innovation in the VA in past two decades has been the introduction of the "Vet Centers" -- 207 walk-in storefront centers where veterans or their families can obtain counseling and reintegration assistance. The centers, operated by VA's "Readjustment Counseling Service" are popular with veterans and their families and – at a total cost of some $100m per year -- provide a highly cost-effective option for veterans who are not in need of acute medical care. The Vet Centers are particularly helpful for families, for example they provide a venue for a soldier's spouse to seek guidance of the veteran is showing mental distress but will not seek help. They also supply bereavement counseling to surviving families of those killed during military service. And they offer a friendlier environment often staffed with recent OEF/OIF combat veterans and other war veterans – unlike VA regional offices which tend to be stuffy, bureaucratic offices located in downtown locations[44].

To date, 144,000 veterans have sought assistance at these centers[45]. However the demand for their services is threatening their ability to provide care. Vet Center managers recently surveyed by Congress said that in 50% of the Centers, the increasing workload is affecting their ability to treat veterans. Some 40% of the Vet Centers have directed veterans for whom individualized therapy would be appropriate into group therapy, and more than one-quarter of the Centers have limited or plan to limit family therapy. Nearly 17% have established waiting lists (or are in the process of setting them up)[46].

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[42] The NPV is calculated over 40 years, at a discount rate of 4.75%, with a peak rate of 50% veterans claiming care by 2016.
[43] High scenario assuming 10% medical inflation rate.
[44] Opinion based on conversations with veterans organizations.
[45] Vet Center costs document, page 3B-11
[46] October 2006 report issued by the House Veterans Affairs Committee, testimony by Vet Center managers.

Currently the centers do not assist veterans in filing disability claims, but provided that the facility had sufficient secure storage space to handle such documents, there is no reason why they could not. The VA has recommended hiring an additional 1000 claims adjudicators – who could be placed in the Vet Centers (an average of 5 each) to help veterans figure out how to claim. The cost of expanding the number of centers, hiring additional staff and placing more claims adjudicators in the centers is minimal.

Transition from DOD Payroll to VA Care

One of the chief bottlenecks in the current system is the soldier's transition from the DOD payroll into the VA benefit system. There are three primary ways that a soldier makes this transition.

A veteran who is discharged regularly, and has some level of disability will typically have to wait 6 months before receiving his or her disability check from the VA. This is a period during which the veterans, particularly those in a state of mental distress, are most at risk for serious problems, including suicide, falling into substance abuse, divorce, losing their job, or becoming homeless.

A second route is to exit via the "Benefits Delivery at Discharge" (BDD) program. This successful program allows soldiers to process their claims up to six months prior to discharge, so they can begin receiving benefits as soon as they leave the military. However, the use of this route has become much more difficult due to the extended deployments, the use of "stop-loss" orders, and the resulting unpredictability about when a soldier will be discharged. Additionally, this program is not available to Reservists and Guardsmen, who comprise 40% of the forces in Iraq and Afghanistan. The VBA claim denial rate is twice as high for Reserve and Guard veterans, possibly due in part to their lack of access to BDD.[47] Consequently the usage of this apparently better route has not been increasing as would have been expected.[48].

For veterans who are more seriously wounded, the process is more complicated as they transition from medical facilities run by DOD into medical facilities run by the VA. For example a wounded veteran may be treated initially at Walter Reed Army Hospital and then transferred to a VA facility. Veterans experience some difficulties is securing the maximum amount of disability benefits at discharge during such transitions, due to a lack of compatibility between the DOD and VA paperwork and tracking systems. The VA complains that the records they receive from DOD are delayed or contain errors, in many cases it is the situation where the data that is tracked is not compatible. This not only creates unnecessary problems in moving veterans through the system but it also makes it more difficult for the data to be analyzed in medical and other studies.

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[47] Active Duty denial rate is 7.6 percent compared with National Guard and Reserve denial rate of 17.8 percent, See Footnote 28

[48] Congressional testimony of Jack McCoy, VBA, March 16, 2006, http://www.va.gov/OCA/testimony/hvac/sdama/060316JM.asp and a VA fact sheet indicate 26,000 BDD claims in 2003, 39,000 in 2004, and 46,000 in 2005. http://www1.va.gov/opa/fact/tranasst.asp

Additionally there are the problems caused by the Pentagon's poor accounting system. GAO investigators have found that DOD pursued hundreds of battle-injured soldiers for payment of non-existent military debts – because DOD financial systems erroneously reported that they were indebted. For example, one Army Reserve Staff Sergeant, who lost his right leg below the knee, was forced to spend 18 months disputing an erroneously recorded debt of $2231 which prevented him from obtaining a mortgage to purchase a home. Another staff sergeant who suffered massive brain damage and PTSD had his pay stopped and utilities turned off because the military erroneously recorded a debt of $12,000. Hundreds of injured soldiers may be in this situation[49].

Overall Assessment and Cost

Overall the US is not adequately prepared for the influx of returning servicemen from Iraq and Afghanistan. There are three major areas in which it is not prepared: claims processing capacity for disability benefits; medical treatment capacity, in terms of the number of health care personnel available at clinics throughout the country, particularly in mental health; and third, there is no preparation for paying the cost of another major entitlement program.

As discussed earlier, the backlog in claims benefit is already somewhere between 400,000 and 600,000. Unless major changes are made to this process, the number of claims pending and requiring attention will reach some 750,000 within the next two years and the pendency period will increase proportionately, resulting in more veterans falling though the cracks that could have been avoided. In addition, veterans whose claims reach different centers in different parts of the country will have widely different experiences, proving highly unfair to those who just happen to be located in areas of greater backlog.

The quality of medical care is likely to continue to be high for veterans with serious injuries treated in VA's new polytrauma centers. However, the current supply of care makes it unlikely that all facilities can offer veterans a high quality of care in a timely fashion. Veterans with mental health conditions are most likely to be at risk because of the lack of manpower and the inability of those scheduling appointments to distinguish between higher and lower risk conditions. If the current trends continue, the VA is likely to see demand for health care rising to 750,000 veterans in the next few years, which will overwhelm the system in terms of scheduling, diagnostic testing, and visiting specialists, especially in some regions[50].

The cost of providing disability benefits and medical care, even under the most optimistic scenario that no additional troops are deployed and the claims pattern is only that of the previous Gulf War, would suggest that at a minimum the cost of providing lifetime disability benefits and medical care is $350 billion. If the number of unique troops increases by another 200,000 to 500,000 over a period of years, this number may rise to

[49] GAO-06-494, "Hundred of Battle-Injured GWOT Soldiers Have Struggled to Resolve Military Debts"
[50] However, the availability of medical care may vary significantly by region.

as high as nearly $700bn. (See Table 5) The funding needs for veterans' benefits thus comprise an additional major entitlement program along with Medicare and Social Security that will need to be financed through borrowing if the US remains in deficit. This will in turn place further pressure on all discretionary spending including that for additional veterans' medical care.

Table 5: Total Veterans Disability and Medical Costs[51]

	LOW	MODERATE	HIGH
Disability	67.6	109.5	126.8
Medical	282.2	315.2	536.0
TOTAL ($Bn)	349.8	424.7	662.8

In the context of the overall costs of the War

Veteran's disability benefits and medical care are two of the most significant long-term costs of the War. As shown in our previous analysis of the costs of the war, the war has both budgetary and economic costs. This paper focuses only on the budgetary costs of caring for veterans. It does not take into account the value of lives lost, or effectively lost due to grievous injury. Not does it take into account the economic impact of the large number of veterans living with disabilities who cannot engage in full economic activities[52].

[51] Total lifetime costs over 40 years, discounted at 4.75% under scenarios described.
[52] This paper considers only the budgetary costs of veterans care. Standard economic theory would treat disability benefits as a transfer payment and deduct these from the economic and social loss associated with veteran's reduced economic lives. This was the methodology used in (stiglitz paper).

Recommendations

a) Medical Care

The Veterans Health Administration will not be able sustain its high quality of care without greater funding and increased capacity in areas such as psychiatric care and brain trauma units. In addition, more funding should be provided for readjustment counseling services by social workers at the Vet Centers. Even doubling the amount of funding for counseling at the Vet Centers is a small amount compared to the funds now being requested for additional recruiting of new soldiers.

(b) Disability Claims Backlog

There are at least three potential methods of reducing the number of pending claims. Perhaps the easiest would be to "fast track" returning Iraq and Afghan war veteran's claims in a single center staffed with highly experienced group of adjudicators who could provide most veterans with a decision within 90 days. At a minimum, all simple claims could be dispatched in this manner. During the past decade, private sector health insurance companies have reengineered their processes and adopted technologies, such as new automated data capture and document processing systems that have dramatically improved their ability to handle large volumes of information. This has allowed the industry to bring the average claim processing time down to 89.5 days. For example, the firm Noridian used technology to enable operators to process four to five times more claims in the same amount of time as under their old system, and to speed the form retrieval process for better customer service[53].

The VA has proposed a more typically governmental solution of adding 1000 more claims adjudicators. Even apart from the cost of $80m or so of adding these personnel, the question is whether adding additional personnel to a cumbersome system is the best possible way to speed up transactions and improve service. A better idea would be to expand the Vet Centers to offer some assistance in helping veterans figure out their disability claims. The 1000 claims experts could be placed inside the Vet Centers (5 per center), thus enabling veterans and their families to obtain quick assistance for many routine claims. Vet Centers would only require minor modifications (secure storage space, additional computers and offices) to fill this role.

The best solution might be to simplify the process -- by adopting something closer to the way the IRS deals with tax returns. The VBA could simply approve all veterans' claims as they are filed – at least to a certain minimum level -- and then audit a sample of them to weed out and deter fraudulent claims. At present, nearly 90 percent of claims are approved. VBA claims specialists could then be redeployed to assist veterans in making claims, especially at VA's "Vet Centers." This startlingly easy switch would ensure that the US no longer leaves disabled veterans to fend for themselves.

[53] KM World, June 1999.

The cost of any solution that reduced the backlog of claims is likely to be an increased number of claims, and a quicker pay-out. If 88% of claims were paid within 90 days instead of the 6 months to 2 years currently required, the additional budgetary cost is likely to be in the range of $500m in 2007.

Conclusions

President Bush is now asking for more money to spend on recruiting in order to boost the size of the Army and deploy more troops to Iraq. But what about taking care of those same soldiers when they return home as veterans? The number of veterans who are returning home with injuries or disabilities is large and growing. We have not paid careful enough attention, or devoted sufficient resources, to planning for how to take care of these men and women who have served the nation.

There has been a tendency in the media to focus on the number of US deaths in Iraq, rather than the volume of wounded, injured, or sick. . This may have led the public to underestimate the deadliness and long-term impact of the war on civilian society and the government's pocketbook. Were it not for modern medical advances and better body armor, we would have suffered even more loss of life.

One of the first votes facing the new Democratic-controlled Congress will be yet another "supplemental" budget request for $100+ billion to keep the war going. The last Congress approved a dozen such requests with barely a peep, afraid of "not supporting our troops". If the new Congress really wants to support our troops, it should start by spending a few more pennies on the ones who have already fought and come home.

Limitations of Data

This paper has been prepared based on the best available data from VA sources, CBO, GAO, and veterans organizations. Reconciling this data has therefore been done to try to generate realistic estimates, but is not precise. It is also difficult to predict with certainty the uptake in the military of benefits and medical care. In all cases this study has been done conservatively, for example it is entirely possible that after the length and grueling nature of this war, that a much higher number – perhaps 2/3 of returning veterans – would seek disability benefits and/or healthcare and the estimates in this paper prove too low.

Issues not addressed

This paper has not attempted to address the cost of taking care of wounded and disabled Iraqi soldiers in Iraq. A number of studies have estimated the fatalities in Iraq, but there are few studies of the number of injuries among the Iraqi military. As the US continues to place an emphasis on developing the Iraqi military to replace it, it is worth asking what the cost to that country will be of providing medical care and any kind of long-term

benefits to those who are fighting. This study excludes VBA benefits such as education, insurance, vocational rehabilitation, and home loan guaranty programs. This study also excludes private, state, and local healthcare, disability, and employment benefits for returning veterans.

Acknowledgements
This paper was prepared with the invaluable assistance of Tony Park, a student at the Kennedy School of Government, and Paul Sullivan, Director of Research and Analysis at Veterans for America. Their contributions are gratefully acknowledged.

Chairman AKAKA. Thank you very much, Mr. Rowan.

My questions are for all of our witnesses. What are your views on VA's capacity to provide needed rehabilitation, case management, and community reintegration services for veterans with traumatic brain injuries and to help their families as caregivers? How can VA improve services to veterans with traumatic brain injuries and their families to help them recover and lead full, productive lives?

I'd like to call on Mr. Blake first.

Mr. BLAKE. Well, Senator Akaka, what I would say first is, I believe the VA is doing a great job already of doing their best to address the needs of particularly the veterans with traumatic brain injury. I think that has probably established itself, along with PTSD, as being at the forefront of conditions being experienced by the OIF/OEF veterans.

Being a user of the VA Medical Center in Richmond, I see what they do there, and I think that it is yeoman's work what they do there. They do a lot with a lot less than any other system outside of the VA would probably be able to handle.

I would say that right now the best thing that could be done for the VA would be to complete appropriations work for their current year because all we are doing is putting them in a bind where even the most important services, which I would consider TBI and a lot of the specialized services to be, are also being strapped to the limits because they cannot hire new staff; they have even had to cut staff in a lot of cases because it is just not there. And for us to continue to expect the VA to provide these much needed services under the situation it is in is just unacceptable.

Chairman AKAKA. Mr. Violante?

Mr. VIOLANTE. Thank you, Mr. Chairman. I am not sure VA has the capacity. I mean, this seems to be the disability from this war, and, unfortunately, the range of severity is almost negligible in some individuals to totally severe in others. And I think VA needs to focus a lot more resources, number one, on identifying individuals that have been exposed to IEDs, whether that be minor exposure or whatever, because we are going to see a lot more of these individuals probably coming forward with disabilities in the future. So I think VA definitely needs more resources focused on this area.

Chairman AKAKA. Mr. Greineder?

Mr. GREINEDER. Thank you, Mr. Chairman. I would agree with my colleagues here at the table. I think VA has done a tremendous job on TBI issues and mental health issues. And I would say that, you know, to get VA the timely funding so they can cover their staff shortages and cover their needs in that area, as well as the funding area.

Chairman AKAKA. Mr. Cullinan?

Mr. CULLINAN. Thank you, Mr. Chairman. I would agree that VA to this point is doing a terrific job with respect to dealing with these issues. I certainly have to associate myself with Mr. Blake's remarks, though, that it is very important to get them the money on time. They simply cannot keep on doing this without getting enough money on time.

The other thing, things like TBI and certain force injuries are uncharted medical and scientific ground, so the area of research

really has to be looked at. We have to identify those individuals, and we have to be able to find out what the things are that are going to beset these individuals as well, and how they can be addressed. So the research is key.

Chairman AKAKA. Mr. Robertson?

Mr. ROBERTSON. Yes, sir. It is very interesting, I was talking to a psychiatrist about this very subject, and he was telling me that most of the TBI injuries, the family members are the ones that are seeing the difference in their conduct and their behavior, and it is the families that are referring them into the hospitals.

I am thinking that maybe we have to do a lot more outreach of educating the family members and spouses, whether it is a video to show them what signs they should be looking for or the kinds of conducts or symptoms traditionally associated with this kind of injury.

The other thing is the separation physicals. I think it is just absolutely critical that when they separate these kids that have been in theater, they ask them specifically: Were you around IEDs? Were you involved in an automobile accident where your Humvee rolled over? Anything that could be documented to show that there was a head injury, because most of these, as you well know, there are no marks left behind. It is kind of like being shot with a bullet made of ice that melts and the evidence is gone, but the results are still pretty traumatic.

Chairman AKAKA. Mr. Rowan?

Mr. ROWAN. Yes, sir. I would concur with my colleagues, particularly Steve's point. I had dinner with some people from Walter Reed recently, and one of the people there was a young lady who had gotten banged up in Afghanistan. And she got sent back to Germany and everything seemed fine, except she then had a massive stroke that put her in a wheelchair. So that point really comes home about following up with them.

Also, we do a terrible job in families. I mean, one of the problems the VA has is we have never figured out what to do with families in any issues—PTSD, physical injury, whatever. And, I mean, I can only say thank God for Fisher Houses in dealing with the folks that are sitting in these places. And, I do not know, maybe we need to work on an appeal in the private sector to develop more Fisher Houses next to the VAs as well as next to Walter Reed and Brooks Army Medical Center and other places like that. But we need to do something.

Chairman AKAKA. Well, I thank you very much for your responses. Before I call on Senator Craig, I just want to tell you that we both want to have joint sessions with VSOs here in Congress. And I want you to know that it is going to come back, and we look forward to that.

Senator Craig?

Senator CRAIG. Mr. Chairman, thank you very much. One question and then one comment.

First and foremost, let me tell you that the Independent Budget serves a very valuable role in our assessment of and evaluation of the Administration and the VA's budget, and its presentation and your involvement in it is not taken lightly.

The President's request for medical care exceeds the Independent Budget recommendations when $2.3 billion in expected collections are factored in. Your organizations, however, do not factor in the expected collections and instead seek full funding from appropriated dollars alone. You do not all have to answer that, but, Carl, possibly you and others could explain why you don't factor in the expected dollars now that we have a very real track record in the budget as to what those collections are.

Mr. BLAKE. Well, Senator Craig, this point was also addressed when we had our meetings with your staff, and I think it is a good point, and it is one of those things where the historical trends in the past have borne out that the VA was really incapable of meeting its collections estimates. And I would be lying if I did not say that it is something that the further down the line we go, the more we will have to kind of re-evaluate it as the VA proves whether it is able to actually do it.

The problem still remains. Although they may collect, let's just say, for instance, 90 percent of their collection estimates this year, there is no guarantee that next year they will not turn right around once again and collect 40 percent or 35 percent. So there is too much risk, I believe, in laying too much on funding the VA health care system in estimates where there is far too much variation in how much collections VA is actually going to recognize.

Senator CRAIG. OK.

Mr. ROBERTSON. Since the American Legion is not part of the IB, I will not have an answer from the Legion's perspective. We have always seen this as treatment for people other than the service connected, the ones where Title 38 says "the Secretary shall provide . . ." That usually covers Priority Groups 1 through 6. And then it says, "The Secretary may provide . . ." and that is the 7s and 8s.

So we have always had the mindset that when the discretionary appropriation is made, it is really made for the 1s through the 6s, and that the 7s and 8s, when eligibility reform was established, every veteran that registered that was a 7 and 8 had to agree to allow third-party collections and copayments. So they agreed to bring money into the system. Where the breakdown has taken place is, number one, the vast majority of our enrollees that are 7s and 8s are Medicare eligible, and VA is prohibited by law from billing Medicare. That is one.

The other one is that if you have an insurance company that says, "If you go outside the PPO of our network of doctors, then it is on you." And in that situation, when we send the bill to them, they send it back and say, "I am sorry. They went outside the network. We do not have to pay you anything." So I was very pleased to see that VA has worked with Medicare in developing a reasonable charge formula, I guess, that is consistent with what Medicare uses when they start sending these bills out to more insurance companies. So, hopefully, more insurance companies will start looking at that and say, "Yes, that is an acceptable charge," and go ahead and pay it.

But throughout the history of the third-party collections, they have never, ever, ever met their goal. And when you are short of

money and that is part of your discretionary appropriations, that means it impacts directly at the health care facility.

Senator CRAIG. Well, thank you all, and the reason I say that, we cannot ignore the obvious, and the obvious is the record. The VA brought in $1.7 billion in collections in 2004, $1.89 billion in 2005, $2 billion in 2006, and is on the pace to collect $2.2 billion this year.

I think it is reasonably safe to assume they are going to meet that target of $2.3 billion, and what I find us doing is ignoring one mighty big slush fund—a $2.3 billion slush fund sitting out in VA.

Now, I hope you are not blinded by your pursuit of a totally funded entitlement program by ignoring the opportunity of reasonable revenue.

Mr. ROBERTSON. May I please respond?

Senator CRAIG. Well, no.

[Laughter.]

Senator CRAIG. Let me make one other observation, Steve.

Mr. ROBERTSON. I will write you a letter.

Senator CRAIG. Please do. Now, I am serious about this.

Mr. ROBERTSON. I am, too.

Senator CRAIG. It is worthy of an open discussion as to what we are all about here because of the obvious increased demands for veterans' appropriate and necessary funding. Also, you know, I am allowed to change my mind on occasion, but when I do, it usually makes headlines. I, therefore, appreciate your ability to change your minds. But let me put into the record, Mr. Chairman, testimony from the DAV in 1996, which means somebody changed their mind, and it says here—and this is the representative of the DAV at that time saying to the then-Chairman: "But everybody else who comes to the system"—and we are talking about the new priorities—"Mr. Chairman, is going to have to pay their own way as they would in any other system, through either copayments, deductibles, or private insurance. So if there is an assumption on the cost of this bill being predicated upon all these new veterans coming into the system and not paying for their care, then it is a faulty assumption and one that drives the cost up." That was 1996. Frankly, almost every veterans organization has changed their mind.

Now, having said that, I think what is also important, the DAV goes on to say, "In the Independent Budget DAV proposes, along with AMVETS, PVA, and VFW, that the Secretary have the discretion to treat these parties at their own expense. We do not request that they be entitled to VA medical care. We believe it would be in the best interest of the veterans and the VA to allow these parties to use VA care at their own expense." That was then. This is now. And in that stretch of time, we have seen a phenomenal growth in this budget, and appropriately so. None of us deny that.

We have explained this before. You have explained it before. I am not criticizing. But I do believe, Mr. Chairman, it is important to let the record show there has been a significant shift in attitude about funding and funding priorities at a time when money is no less difficult to come by as it relates to providing our veterans with appropriate service. That is why, Steve, I wanted to go on and complete this. I am running fast to catch up with myself to get to an-

other meeting, and, gentlemen, I would never deny you access to the record to express why you have changed and why you see it as necessary to change the position that was held then by your organizations and what is held today.

Thank you, Mr. Chairman.

[Hearing transcript excerpt follows:]

HEARING TRANSCRIPT EXCERPT, VETERANS HEALTH CARE ELIGIBILITY PRIORITIES (PART I), HELD ON MARCH 20, 1996, SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman SIMPSON. Which veterans should receive free medical care from the Federal Government and what services should they receive?

Mr. GORMAN (DAV). I think the premise today that you would build a system on really was the premise it was built on when it was first enacted, and that is to take care of *the wartime disabled veteran . . . we believe as an organization of service-connected veterans that that's who the system should treat primarily.*

Mr. VITIKACS (The American Legion). I certainly would concur that *service disabled veterans are the primary constituents of the VA medical care system.* I think that if we were newly creating a VA system today, we would also support the current eligibility where *veterans unable to defray the cost of their own health care would be given consideration.*

Mr. CURRIEO (VFW). I believe *anyone who in the service of their country was injured or disabled* in any way that needs medical treatment once they leave that military service, *if they were injured and disabled in the line of duty, which doesn't necessarily mean combat, it could be training accidents,* should be entitled to some type of health care once they leave the service without any expense to themselves.

Mr. MANSFIELD (PVA). I think, in response to some of the questions, what PVA is looking for is we think that *service-connected veterans, catastrophically disabled veterans, veterans with limited income are those that ought to be the focus of VA providing health care. Other veterans with funding streams to be retained by the VA are what we're talking about in additional care.*

Chairman SIMPSON. If you say expanded and improved VA health benefits won't open the floodgates, then are you saying to us that veterans will not seek free care? If so, why not?

Mr. GORMAN (DAV). Although all these veterans may be eligible for care, and they are all eligible for care now, our proposal does not in any way stipulate or even imply that their care would not be paid for by somebody. The service-connected veteran and the Category A veteran as defined in the bill would continue to be provided care with appropriated dollars, as it should be. . . . *But everybody else who comes to the system, Mr. Chairman, is going to have to pay their own way, as they would in any other system, through either copayments, deductibles, or private insurance. So if there's an assumption on the cost of this bill being predicated upon all these new veterans coming into the system and not paying for their care, then it is a faulty assumption and one that drives the cost up.*

Mr. VITIKACS (The American Legion). The American Legion has never, and will never, advocate the VA be a charity system. . . . In addition to VA achieving greater efficiencies and reducing redundancies within the VIS networks and to right-size the system through mission changes, *we believe that the way to arrive at budget neutrality is through developing new revenue sources into the system. . . .*

Senator ROCKEFELLER (post-hearing Question For the Record). To what extent do you think it is important that access to VA care be provided to (a) Higher income veterans with no service-connected disabilities? (b) Dependents of veterans?

Mr. GORMAN (DAV). *In the Independent Budget, DAV proposes, along with AMVETS, PVA, and VFW, that the Secretary have the discretion to treat these parties at their own expense. We do not request that they be entitled to VA medical care. We believe it would be in the best interest of veterans and VA to allow these parties to use VA care at their own expense.*

Mr. VITIKACS (The American Legion). The American Legion believes that higher income nonservice-connected veterans and certain dependents of eligible veterans should be permitted access to the VA health care system *by paying premiums, copayments and deductibles.* These additional revenue streams would help to ensure the long-term viability of the VA health care system. . . The normal appropriations process would ensure funding for Category A veterans and the conversion of VA to a market-based, managed care system would *attract other paying customers.*

Chairman AKAKA. Thank you very much. Your words and your statement is now part of the record, Senator Craig.

We will submit the rest of the questions that Committee Members have to you for the record.

I want to thank you all for your responses. We look forward to working with you on veterans' issues this year. The hearing on the Fiscal Year 2008 Budget for Veterans' Programs is now adjourned.

[Whereupon, at 12:30 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

INTRODUCTION

The American Federation of Government Employees, AFL–CIO, which represents more than 600,000 Federal employees who serve the American people across the Nation and around the world, including roughly 150,000 employees in the Department of Veterans Affairs (VA), is honored to submit a statement regarding the VA's Fiscal Year (FY) 2008 budget.

AFGE commends Chairman Akaka for his leadership in securing adequate funding for veterans in the face of VA's unpredictable budget process. It is time to give veterans more predictability through an assured funding process. As Chairman Akaka so eloquently stated last month, "VA must not be seen simply as another department or agency coming hat in hand to seek funding." The evidence of a broken funding process is overwhelming: a $3 billion shortfall 2 years ago, hiring freezes, hospitals operating in the red, and 400,000 pending benefit claims last year, while this year, the VA is operating on its twelfth continuing resolution in thirteen years.

AFGE members see first hand both the costs of war and the costs of a discretionary VA funding formula. Chronic underfunding and financial uncertainty cause tremendous wear and tear on VA services and the employees who provide them. Our members who work in the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) express growing anxiety, sometimes bordering on desperation over the lack of resources, staffing and training they need to do their jobs. Many VBA employees who process the claims of service-connected veterans were themselves once on the receiving end of the claims process. Many social workers in VHA providing PTSD treatment bring their own valuable veteran's perspective to their jobs. The large numbers of veterans in low wage VA jobs who launder hospital bed linens and clear the snow on hospital grounds take particular pride in meeting the needs of fellow veterans. In short, AFGE speaks for employees and veterans in calling for a strong and predictable VA budget because we too believe that shortchanging veterans is unacceptable.

NEED FOR MORE OVERSIGHT

Adequate funding goes hand in hand with adequate oversight. Congress and the public must be able to determine whether these precious dollars are being spent cost effectively and in the best interests of veterans. Unfortunately, there is far too little transparency in VA spending at the present time. As the Government Accountability Office (GAO) has found, the VA does a poor job of budget forecasting, relying on incorrect assumptions. In the first quarter of Fiscal Year 2006, VHA treated nearly 34,000 more returning OIF and OEF veterans than it had predicted it would treat for the entire year. The VA does not adequately track how many health care dollars are spent on illegal cost comparison studies, according to another GAO study. Finally, last year, GAO found that millions of dollars budgeted for mental health strategic initiatives had not been spent.

Stronger reporting requirements for VA spending are badly needed. It appears that the VA has suffered no consequences for filing several years of incomplete reports on contracting out that are required by Federal law (38 U.S.C. § 305). It also appears that the quarterly reports required by the Fiscal Year 2006 VA appropriations law have not provided much of a vehicle for oversight. For example, those quarterly reports should help track the movement of funds between the three medical care categories. Yet, AFGE members continue to report "borrowing" between medical accounts. Along the same lines, the proposed budget does not adequately explain why 5,689 food service jobs suddenly fit better in Medical Services than Medical Facilities.

AFGE also urges the Committee to conduct oversight of other problem spending areas. First, it is very difficult to determine how much VHA spends on direct patient care FTEs as compared to supervisory and administrative FTEs. We are especially concerned about the enormous growth in VISN budgets. One of the original goals of the VISN reorganization was to reduce the need for management positions, and each VISN was expected to have 8 to 10 FTEs. Yet currently, total VISN employment is nearly three times that amount (638 FTEs). Seven of the 23 VISNs have 30 or more employees. AFGE also encourages more oversight of VHA dollars spent on bonuses.

THE PRESIDENT'S FISCAL YEAR 2008 BUDGET PROPOSAL

As proud and longtime supporters of the Independent Budget (IB), AFGE's overall concern with the President's budget proposal is that the proposed funding levels for VHA and VBA fall short of the IB's recommendations, which forecasts veterans' needs using sound, systematic methodology. We also concur with the IB's recommendation to restore eligibility to Category 8 veterans. AFGE rejects doubling of copays, new user fees or any other policies that shift costs to moderate income veterans and shrink deficits by pushing veterans away.

Despite the Administration's contentions, this proposed budget is not gimmick-free. Even though drug copays and user fees are not part of this year's medical care budget, the Administration acknowledges that these dollars could affect its 2009 appropriations request. Another familiar gimmick is to follow a strong first year budget with a decrease in funding over the next 4 years; according to the Center for Budget and Policy Priorities, veterans' health care would undergo large cuts between 2008 and 2012.

Fee Basis Care

One of the most harmful byproducts of underfunding is excessive reliance on contract care. Federal law and good policy dictate that fee basis care should be provided to veterans in limited circumstances. AFGE is concerned that the proposed Fiscal Year 2008 budget continues a dangerous trend toward increased reliance on fee basis care, in lieu of hiring more VA medical professionals and timely construction of new hospitals and clinics. The number of outpatient medical fee basis visits estimated for Fiscal Year 2008 represents a 27 percent increase in 3 years. Veterans deserve a better explanation of VA's growing reliance on fee basis care, in the face of constant accolades in the medical community about the quality of VA health care. AFGE also has concerns about the potential of VA's newest fee basis initiative, Project HERO, to waste scarce medical dollars by increased use of contract care.

Long Term Care

The Administration has once again failed to propose adequate funding for institutional long term care. There are insufficient resources in the community to shift large numbers of aging and disabled veterans to noninstitutional care. Some veterans must remain in institutional care and need beds that are currently in short supply. In addition, AFGE questions estimates in the proposed budget that predict declines in operating levels for rehabilitative, psychiatric, nursing home and domiciliary care.

VBA

The proposed priority system for processing OIF and OEF claims leaves many unanswered questions. Admiral Cooper's assurance at the budget briefing that this new system will "hopefully" not impact other veterans already facing long delays in claims processing is not enough. VBA needs to hire enough staff to process all benefit claims in a timely manner. Specific legislation should be required to impose any priority system in VBA.

The proposed budget does not contain adequate justification for its request for dollars to conduct new contracting out pilot projects for medical exams to determine service-connected disabilities and income matching. AFGE strongly encourages this Committee to inquire as to whether it is in veterans' interests to contract out this work, and whether doing so violates competition requirements in the OMB A–76 Circular and 2006 Transportation-Treasury Appropriations law.

The proposed increase in staff for the processing of disability claims is a step in the right direction. However, the proposed decrease in staff for the Pension Maintenance Centers is definitely a step in the wrong direction. Currently, the Pension Maintenance Centers have too few authorizers to review cases, while adjudicators are pressured to give claims a limited review to meet production standards. If VBA proceeds with plans to shift the processing of original pension claims from the Regional Offices to the Pension Maintenance Centers, additional staff will be needed.

REPORTS FROM THE FRONT LINES

The following examples illustrate how underfunding and financial uncertainly adversely impact the delivery of health care to veterans:

Nurses

• Pay: Despite widely recognized problems with recruitment and retention, RNs in every VISN report problems with the locality pay process established by 2000 nurse legislation. Managers often refuse to provide locality pay increases even after conducting surveys, claiming lack of funds. The result is a worsening of the current nurse recruitment and retention problem and fewer nurses at veterans' bedsides.

• Contract Nurses: Turning to contract nurses as a stopgap solution wastes scarce dollars and impacts quality. AFGE commends Chairman Akaka and Senator Salazar for requesting a GAO study of the growing VA practice of using contract nurses to address nursing shortages resulting from budget-driven hiring freezes.

• Floating: Another frequently used stopgap solution that hurts patient care is requiring nurses to rotate between two or more short-staffed clinics.

• Mandatory Overtime: Despite provisions in 2004 legislation to reduce mandatory nurse overtime, hospitals continue to rely on mandatory overtime to address staffing shortages.

• Patient Safety Equipment: AFGE urges this Committee to ensure that all VA medical facilities have the funds to purchase patient lifting equipment that reduce nurse back injuries and patient tears.

Physicians and Dentists

In every VISN, physicians and dentists report difficulty getting adequate market pay increases and performance pay awards, despite clear language in 2004 physicians pay legislation. Facility directors have contended that they lack the funds to increase pay and give awards, even before they convened any panels to set market pay or conducted evaluations of individual physician performance. Management also cries "budget" in refusing to reimburse physicians for continuing medical education, again despite clear language in Title 38 entitling full-time physicians to up to $1,000 per year.

On call physicians are routinely scheduled for weekend rounds and are not provided any compensation time for weekend work. Primary care panel sizes are at maximum levels regardless of the complexity of various cases. Physicians with heavy workloads must also cover large patient loads of other doctors on leave as there are no additional physicians available.

The results of these ill-advised policies are widespread shortages of specialty physicians throughout the VA, and shorthanded primary care clinics with enormous patient caseloads.

Delays in Diagnostic Testing

Short staffing causes significant delays in medical testing. According to recent report from a VISN 20 facility, veterans there face significant delays in obtaining sleep studies because the sleep clinic lacks adequate staff to review the results. As a result, it takes 5 to 6 months to get reports read (over double the wait time a year ago). The facility is also experiencing extensive delays in getting the results of bone density studies because the Imaging Department has only one part-time employee to read the scans.

Mental Health

Due to a chronic shortage of psychiatrists in many facilities, new veterans entering the VA health care system must wait several months to see a psychiatrist. While there has been an increase in hiring of new social workers, the level is still below that of 10 years ago. Heavier caseloads prevent social workers from spending more time with patients and providing other support such as visiting patients at homeless shelters.

CONCLUSION

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Senate Committee on Veterans Affairs. We look forward to working with Chairman Akaka and Ranking Member Craig to ensure that the VA budget adequately meets the needs of our veterans in Fiscal Year 2008 and beyond. We believe assured funding and increased oversight are essential to meeting that goal.

PREPARED STATEMENT OF THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH

On behalf of the Friends of VA Medical Care and Health Research (FOVA), thank you for your continued support of the Department of Veterans Affairs (VA) Medical and Prosthetic Research Program. FOVA is a coalition of over 80 national academic, medical and scientific societies; voluntary health and patient advocacy groups; and Veterans Service Organizations committed to ensuring high-quality health care for our Nation's veterans. The FOVA organizations greatly appreciate this opportunity to submit testimony on the President's proposed Fiscal Year (FY) 2008 budget for the VA research program. For Fiscal Year 2008, FOVA recommends an appropriation of $480 million for VA Medical and Prosthetic Research and an additional $45 million for research facilities upgrades to be appropriated through the VA Minor Construction account.

FOVA recognizes the significant budgetary pressures this committee bears and thanks both the House and Senate Committees on Veterans Affairs for their Fiscal Year 2007 views and estimates with regard to the VA Medical and Prosthetic Research program. The committees' recommended increases in VA research funding of between $28 million and $51.5 million over the President's Fiscal Year 2007 budget request for the VA research program affirm your ongoing support for improving the health of our Nation's veterans. FOVA also thanks Senators Akaka and Craig for their strong leadership of this committee and for leading efforts in the Senate to encourage the Senate Committee on Appropriations to appropriately fund the VA research program. FOVA looks forward to working with you to develop views and estimates for Fiscal Year 2008 that reflect this same commitment to medical research for the benefit of veterans and, ultimately, all Americans.

VA MEDICAL AND PROSTHETIC RESEARCH IS NECESSARY FOR SUPERIOR VETERANS HEALTH CARE

Recent stagnate funding has jeopardized the national leadership status of the VA research program. Significant growth in the annual VA research appropriation is necessary to continue to achieve breakthroughs in health care for the current population of veterans and to develop new means for addressing the health care needs of the Nation's new veterans.

For Fiscal Year 2008, the Bush Administration has yet again recommended a budget that cuts funding for the VA research program. When biomedical inflation is considered—the Biomedical Research and Development Price Index for Fiscal Year 2008 is projected at 3.7 percent—the research program will be cut even more significantly than the $1 million in current dollars. Just to keep pace with the previous year's spending, an additional $15 million, for a total of $427 million, is required.

FOVA's $480 million recommendation for VA research funding represents an inflation adjustment for the program against the Fiscal Year 2003 baseline. Unfortunately, this recommendation does not even address the additional funding needed to address emerging needs for more research on posttraumatic stress disorder (PTSD), long-term treatment and rehabilitation of veterans with polytraumatic blast injuries, and genomic medicine.

The VA Medical and Prosthetic Research program has been one of the Nation's premier research endeavors. The program has a strong history of success as illustrated by the following examples of VA accomplishments:

- Developed effective therapies for tuberculosis.
- Invented the implantable cardiac pacemaker, helping many patients prevent potentially life-threatening complications from irregular heartbeats.
- Performed the first successful liver transplants.
- Developed the nicotine patch.
- Found that an implantable insulin pump offers better blood sugar control, weight control, and quality of life for adult-onset diabetes than multiple daily injections.
- Identified a gene associated with a major risk for schizophrenia.
- Launched the first treatment trials for Gulf War Veterans' Illnesses, focusing on antibiotics and exercise.
- Began the first clinical trial under the Tri-National Research Initiative to determine the optimal antiretroviral therapy for HN infection.
- Launched the largest-ever clinical trial of psychotherapy to treat PTSD.
- Demonstrated the effectiveness of a new vaccine for shingles, a painful skin and nerve infection that affects older adults.

• Discovered—via a 15-year study of 5,000 individuals—that secondhand smoke exposure increases the risk of developing glucose intolerance, the precursor to diabetes.

VA strives for improvements in treatments for conditions with a prevalence among veterans greater than in the general population, including: diabetes, substance abuse, mental illnesses, heart diseases, and prostate cancer. The VA research program also focuses its efforts on service connected conditions, including spinal cord injury, paralysis, amputation, and sensory disorders.

VA is equally obliged to develop better responses to the grievous conditions suffered by veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), such as extensive bums, multiple amputations, compression injuries, and mental stress disorders. Additional increases are also necessary for continued support of new initiatives in neurotraumas, including head and cervical spine injuries; wound and pressure sore care; pre- and post-deployment health issues with a particular focus on post-traumatic stress disorder; and the development of improved prosthetics and strategies for rehabilitation from polytraumatic injuries. These returning OIF and OEF veterans have high expectations for returning to their active lifestyles and combat.

The seamless mental and physical reintegration of these soldiers is a challenge, but the VA Medical and Prosthetic Research Program can and will address these needs. However, without appropriate funding, VA will be ill-equipped to address the needs of the returning veteran population while also researching treatments for diseases that affect veterans throughout the course of their lives and for which they will seek treatment from VA medical facilities.

To address these long-term needs, VA has a distinct opportunity to recreate its health care system and provide progressive and cutting edge care for veterans through genomic medicine. Innovations in genomic medicine will allow the VA to track genetic susceptibility for disease and develop preventative measures; predict response to medication; and modify drugs and treatment to match an individual's unique genetic structure. VA is the obvious choice to undertake substantial research in genomic medicine as the largest integrated health care system in the world with an advanced and industry-leading electronic health record and a dedicated population for sustained research, ethical review, and standard processing.

While advances in genomic medicine show promise in aiding the discovery of new, personalized treatments for diseases prevalent among many veterans seeking treatment at VA hospitals, there is also evidence that genomic medicine will greatly help in the treatment and rehabilitation of returning OIF/OEF veterans. For instance, research can target the human genome for insight into individual capacity for the healing of wounds. Additional studies have considered the differences between genes that aid in healing and genes that cause inflammation and its sideeffects. Advancements in this field can drastically influence the treatment of injured soldiers and may play a large role in the long-term treatment of surgical patients and amputees.

The VA genomic medicine project will require sustained increases in funding for the VA research program over the next decade, at least. A VA pilot program for banking genetic information that involves 20,000 individuals and 30,000 specimens (with the capacity to hold 100,000 specimens) provides estimates that approximately $1,000 will be necessary to conduct genetic analyses of each specimen. The potential advances that can be achieved with regard to PTSD and veteran-related diseases rely on an expansion of tissue banking as the crucial information generating step that will inform future ongoing research and the development of new treatments.

VA RESEARCH FACILITIES MUST BE UPDATED TO MEET SCIENTIFIC OPPORTUNITIES

State-of-the-art research requires state-of-the-art technology, equipment, and facilities in addition to highly qualified and committed scientists. Modem research cannot be conducted in facilities that more closely resemble high school science labs than university-class spaces. Modern facilities also help VA recruit and retain the best and brightest clinician scientists. In recent years, funding for the VA Minor Construction Program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. Many VA facilities have run out of adequate research space, and ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Under the current system, research must compete with other facility needs for basic infrastructure and physical plant improvements which are funded through the minor construction appropriation.

FOVA appreciates the inclusion within the House-passed Military Quality of Life and Veterans' Affairs and Related Agencies Fiscal Year 2007 appropriations bill of

an additional $12 million to address research facility infrastructure deficiencies. The House Committee on Appropriations also gave attention to this problem in the House Report accompanying the Fiscal Year 2006 appropriations bill (P.L. 109–114), which expressed concern that equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure VA's research facilities remain competitive. The report noted that more resources may be required to ensure that research facilities are properly maintained to support VA's research mission. To assess VA's research facility needs, Congress directed VA to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, along with suggestions for correction. Unfortunately, in its Fiscal Year 2008 budget submission, VA stated that this review, already underway for the past year, will take an additional 3 years to complete.

Meanwhile, in May, 2004, Secretary of Veterans Affairs Anthony J. Principi approved the Capital Asset Realignment for Enhanced Services (CARES) Commission report that called for implementation of the VA Undersecretary of Health's Draft National CARES Plan. The CARES Plan recommended at least $87 million to renovate existing research space. FOVA believes this estimate should be sufficient justification for an increase in the minor construction program to begin a significant modernization program. However, based on pre-2004 assessments of VA research facilities, FOVA believes a complete assessment of research infrastructure needs will likely require a facilities improvement investment of more than $300 million across the 75 VA medical centers that conduct significant amounts of VA funded research. The urgency of VA funding for facilities is more heightened now than ever given the difficulties facing many affiliated non-profit research corporations, which have historically contributed to the modernization of VA research facilities.

FOVA believes Congress should establish and appropriate a funding stream specifically for research facilities using the VA assessment resulting from the Fiscal Year 2006 report language. In the meantime, to ensure that funding is adequate to meet both immediate and long-term needs, FOVA recommends an annual appropriation of $45 million in the minor construction budget dedicated to research facilities improvements. This appropriation is a critical interim step to ensure VA can continue to conduct state-of-the-art research.

THE INTEGRITY OF VA'S INTRAMURAL, PEER-REVIEW SYSTEM MUST BE PRESERVED

As a perquisite for membership, all FOVA organizations agree not to pursue earmarks or designated amounts for specific areas of research in the annual appropriation for the VA research program. The coalition urges you to take a similar stance in regard to Fiscal Year 2008 funding for VA research for the following reasons:

- The VA research program is exclusively intramural. Only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA research awards originating from the VA research appropriation. Compromising this principle by designating funds to institutions or investigators outside of the VA undermines an extremely effective tool for recruiting and retaining the highly qualified clinician-investigators who provide quality care to veterans, focus their research on conditions prevalent in the veteran population, and educate future clinicians to care for veterans .
- VA has well-established and highly refined policies and procedures for peer review and national management of the entire VA research portfolio. Peer review of proposals ensures that VA's limited resources support the most meritorious research. Additionally, centralized VA administration provides coordination of VA's national research priorities, aids in moving new discoveries into clinical practice, and instills confidence in overall oversight of VA research, including human subject protections, while preventing costly duplication of effort and infrastructure. Earmarks have the potential to circumvent or undercut the scientific integrity of this process, thereby funding less than meritorious research.
- VA research encompasses a wide range of types of research. Designating amounts for specific areas of research minimizes VA's ability to fund ongoing programs in other areas and forces VA to delay or even cancel plans for new initiatives. Biomedical research inflation alone, estimated at 3.8 percent for Fiscal Year 2005, 3.5 percent for Fiscal Year 2006, and 3.7 percent for Fiscal Year 2007, has reduced the purchasing power of the R&D appropriation by $44.9 million over just 3 years. In the absence of commensurate increases, VA is unable to sustain important research on diabetes, hepatitis C, heart diseases, stroke and substance abuse, or address emerging needs for more research on post traumatic stress disorder and long-term treatment and rehabilitation of polytraumatic blast injuries. While Congress

certainly should provide direction to assist VA in setting its research priorities, earmarked funding exacerbates ongoing resource allocation shortages.

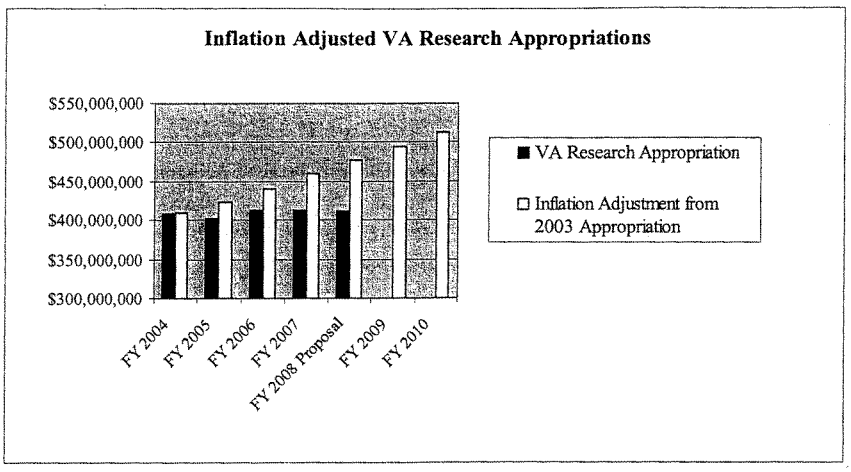
VA MEDICAL AND PROSTHETIC RESEARCH WILL THRIVE WITH YOUR SUPPORT

With its modest research funding, the VA Medical and Prosthetic Research Program has yielded the important scientific discoveries outlined above, competed successfully for over $1 billion annually in funding from other governmental research programs as well as the private sector, produced multiple Nobel Laureates and recipients of other major research recognitions, and added over 2,900 papers annually to the scientific literature. However, VA's modest funding has also required that scientific awards be capped at $125,000 annually, a level significantly lower than the average award amount for the National Institutes of Health, for example. The $125,000 cap is also lower than the cap on funding from earlier in this decade, a tradeoff VA leadership has had to make to continue funding the same number of grants it has historically supported. Modest funding has also limited the capacity of the VA career development program and forced VA to cut funding to important program areas including aging, degenerative diseases of bones and joints, infectious diseases, and kidney disorders.

Congresses' strong past support for the VA research program has been encouraging. FOVA believes the crises and opportunities facing VA research necessitate a significant boost in Federal funding for the program. With such funding, VA can maintain its leadership role in developing resources to address the immediate health care needs of veterans emerging from OIF/OEF as well as the long-term needs of these veterans and those who served the country in the 20th century.

Again, FOVA appreciates the opportunity to present our views to the Committee. While research challenges facing our Nation's veterans are significant, if given the resources, we are confident the expertise and commitment of the physician-scientists working in the VA system will meet the challenge.

[The Inflation Adjusted VA Research Appropriations chart follows:]


Inflation Adjusted VA Research Appropriations
$550,000,000
$500,000,000
$450,000,000
$400,000,000
$350,000,000
$300,000,000
FY 2004
FY 2005
FY 2006
FY 2007
FY 2008 Proposal
FY 2009
FY 2010
VA Research Appropriation
Inflation Adjustment from 2003 Appropriation

FOVA MEMBERSHIP

Administrators of Internal Medicine
Alliance for Academic Internal Medicine
Alliance for Aging Research
American Academy of Child and Adolescent Psychiatry
American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Association for the Study of Liver Diseases
American Association of Anatomists
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Spinal Cord Injury Nurses
American Association of Spinal Cord Injury Psychologists and Social Workers
American College of Chest Physicians
American College of Clinical Pharmacology
American College of Physicians
American College of Rheumatology
American Dental Education Association
American Federation for Medical Research
American Gastroenterological Association
American Geriatrics Society
American Heart Association
American Hospital Association
American Lung Association
American Military Retirees Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Association
American Paraplegia Society
American Physiological Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Society for Bone and Mineral Research
American Society for Pharmacology and Experimental Therapeutics
American Society of Hematology
American Society of Nephrology
American Thoracic Society
Association for Assessment and Accreditation of Laboratory Animal Care International
Association for Research in Vision and Ophthalmology
Association of Academic Health Centers
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Schools and Colleges of Optometry
Association of Specialty Professors
Association of VA Chiefs of Medicine
Association of VA Nurse Anesthetists
Blinded Veterans Association
Blue Star Mothers of America
Clerkship Directors in Internal Medicine
Coalition for Health Services Research
Digestive Disease National Coalition
Federation of American Societies for Experimental Biology
Gerontological Society of America
Gold Star Wives
Hepatitis Foundation International
International Foundation for Functional Gastroenterological Disorders
Juvenile Diabetes Research Foundation International
Legion of Valor of the USA, Inc.
Medical Device Manufacturers Association
Medicine-Pediatrics Program Directors Association
Military Officers Association of America
National Alliance on Mental Illness
National Association for the Advancement of Orthotics and Prosthetics

National Association for Uniformed Services
National Association of VA Dermatologists
National Association of VA Physicians and Dentists
National Association of Veterans' Research and Education Foundations
National Mental Health Association
Nurses Organization of Veterans Affairs
Osteogenesis Imperfecta Foundation
Paralyzed Veterans of America
Paralyzed Veterans of America Spinal Cord Research Foundation
Partnership Foundation for Optometric Education
Society for Investigative Dermatology
Society for Neuroscience
Society for Women's Health Research
Society of General Internal Medicine
Spinal Cord Research Foundation
The Endocrine Society
United Spinal Association
Veterans Affairs Physician Assistant Association
Veterans of the Vietnam War and the Veterans Coalition
Vietnam Veterans of America

THE INDEPENDENT BUDGET RESPONSE TO WRITTEN QUESTIONS
SUBMITTED BY HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Question 1. I would like your comments on VA's proposed enrollment fee and increase in the prescription drug copayment for Priority 7 and 8 veterans-both of which the Administration has repeatedly proposed. What are the implications of these policies? How many veterans do you estimate would be drive out of the system?

Answer. Although the Administration's proposal will not have direct impact on veterans' health care funding, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug copayments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1,000,000 veterans will choose not to enroll.

It is astounding that this Administration would continue to recommend policies that would push veterans away from the best health care system in the world. The Independent Budget contends that veterans should not have to pay an additional price to utilize the VA health care system, when that price was already paid through their service. Furthermore, it is not appropriate to compare the VA system and these new proposed fees to the TRICARE system and the fees that enrolled retirees pay. TRICARE serves as an insurance program both for the retiree and his or her family. A veteran's family has only limited access to the VA health care system. We appreciate the fact that Congress has soundly rejected these proposals in the past and we hope that you will do so once again.

Question 2. How long should a veteran or dependent have to wait to have his or her claim decided?

Answer. While the IB does not make recommendations regarding a specific amount of time considered reasonable for a veteran to await a claims decision, we appreciate Chairman Akaka's question and effort to establish a benchmark for the Department of Veterans Affairs (VA) to strive for in claims processing times. The IB does not normally make such recommendations because we believe the VA should continually strive to increase efficiency, though its primary focus should be on producing accurate decisions that must not be appealed. Not withstanding this position, the IB would be pleased with the progress made if VA were able to attain the goals it has already established for itself. In 2001, the Secretary of Veterans Affairs' Claims Processing Task Force goal was to reduce the waiting period by fifty percent. According to the VA Web site, the average processing time then was 202 days, so the goal was to reduce it to 101 days. The Veterans' Claims Assistance Act of 2000 and other factors have impacted that goal and the VA's new goal is to reduce claims processsing time to 145 days. Clearly, disabled veterans should have to wait as little as possible to receive benefits to which they are entitled, but a 145-day waiting period would certainly be preferable to the length of time that is cur-

rently required. Again, while efficiency is important, the FY 2008 IB emphasizes that VA's main focus should be on quality rather than quantity.

Question 3. As you know, improved cooperation between VA and DOD to achieve a seamless transition between the two Departments for separating servicemembers is one of my top priorities. I was glad to see The Independent Budget's recommendation that VA and DOD ensure that servicemembers have a seamless transition from military to civilian life. Please share your thoughts on what the Departments can do to improve on their performance and reach this goal.

Answer. The Independent Budget Veterans Service Organizations (IBVSO) believe that regardless of who is responsible for addressing weaknesses in the process, seamless transition is a responsibility that both agencies must bear equally. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, bureaucratic inertia, and technological backwardness. It is disconcerting comparing the current state of the seamless transition process to the potential extraordinary accomplishments of which the DOD and VA are capable. We recommend greater vigilance from Congress in its oversight responsibilities on issues hampering the seamless transition of servicemembers, possibly through an informal workgroup for point specific issues regarding strategic goals in the Joint Strategic Plan approved by the VA–DOD Joint Executive Committee. Additionally, we recommend joint committee hearings with the Senate Committee on Armed Services for greater transparency and oversight of the VA–DOD Joint Executive Council activities including the implementation of the Joint Strategic Plan.

Issues regarding fundamental components of the process remain to which we address recommendations including the development of electronic medical records that are interoperable and bidirectional, allowing for two-way electronic exchange of computable health information; occupational and environmental exposure data; and, an electronic Discharge Document (DD) 214. At a minimum, this would allow VA to expedite the process and give the servicemember faster access to health care and benefits. In addition, implementing a mandatory single separation physical as a prerequisite of promptly completing the military separation process would address many issues in the transitioning of benefits and services for servicemembers entering civilian life. Although the physical examinations of demobilizing reservists have improved in recent years, there are still a number of soldiers who "opt out" of the physical examinations, even when encouraged by medical personnel to obtain them. Finally, we recommend additional funding for the Army Wounded Warrior Program and Marine for Life programs to allow for appropriate expansion of these programs to address the needs of more seriously disabled soldiers and Marines. With a high number of severely injured servicemembers returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance these successful programs.

Question 4. Given that VBA continues to fall behind in workload pending versus workload completed, what are some immediate steps that can be taken to give some relief to veterans who are waiting to have their claims adjudicated?

Answer. The IB appreciates the Chairman's innovative perspective with regard to providing benefits to disabled veterans as quickly as possible. Clearly, doing so would require some degree of certainty that such veterans will be eligible for service-connected benefits. Otherwise, such a grant would merely create an overpayment and indebtedness to the Government for veterans whose claim is denied. The VA already utilizes authority to grant immediate benefits via "memorandum ratings" to veterans, such as those severely injured in combat, who will unquestionably be entitled to at least twenty percent service connected disability compensation. The memorandum rating is a temporary rating that is for the purpose of establishing entitlement to Vocational Rehabilitation and Employment (VR&E). With entitlement to VR&E established, disabled veterans can begin their lengthy transition into the civilian job market and lifestyle.

Perhaps this process could be used as a template to deliver additional benefits to disabled veterans awaiting their final rating decisions. Most importantly, VA should have sufficient resources to enable it to make timely claims decisions. This would take into consideration the irreducible amount of time required for responses to requests for information, including turnaround time for mailing; the minimum number of days in queue to maintain minimum inventory necessary for having work on hand, maintaining even production; and, reasonable task times.

Question 5. The Department of Veterans Affairs Personnel Enhancement Act of 2004 was intended to reform the pay and performance system used by VA for hiring and retaining its physicians and dentists. Now that we are in the first full year of implementation, can you give us a sense of how well VA has implemented this legis-

lation and if it is truly assisting VA in recruiting and retaining the best and brightest physicians?

Answer. We do not detect any notable change in VA's pace or methods for recruiting physician staff that we can attribute to enactment of Public Law 108–445. We are confident that VA managers of health care want to obtain the "best and brightest" in physicians and all staff who care for veterans, but we cannot verify that result with any objective data that can be linked to passage of the Act. We are concerned about whether VA's stated support for its passage, provided by the Under Secretary for Health at a hearing before your House counterpart on October 23, 2003, has been fulfilled. The Under Secretary testified as follows:

"Also, a national shortage of many physician specialties critical to our health care mission further affects our ability to fill key vacancies. In these shortage specialties, VA total compensation lags behind private or academic sectors by as much as 67 percent. If we are to maintain our tertiary care capability and our capacity to offer a full range of health care services to veterans, including those now serving in far away parts of the world, we must be able to offer competitive salaries. For several specialties, we are losing staff faster than we can hire them. In some critical specialties, our turnover rate exceeds 25 percent a year. Many facilities are not actively recruiting, as Mr. Rodriguez pointed out, to fill some key vacancies because they simply cannot find viable candidates at current VA salary rates. It is estimated that there are over 900 such positions nationwide for physician specialties. Non-competitive pay and benefits are also reflected in dramatic increases in our scarce specialty, fee basis, and contractual expenditures. These expenditures, which are necessitated when we cannot hire physicians, have risen from $180 million a year in 1995 to over $850 million a year last year. Additionally, we increasingly must hire non-U.S. citizens under the VA's J–1 visa waiver authority, and international medical graduates now constitute almost 30 percent of our entire VA physician workforce. The problems with the current system are clear. Special pay rates are fixed in statute so that over time, their values are eroded by inflation, and VA pay falls behind the market. We now pay the maximum authorized amounts for some scarce specialists, and have no discretion under existing statute to pay more to retain these mission critical employees."

The premise in Congressional passage of the bill was that these numbers (of vacancies in specialty physicians, and the costs for contracting for scarce medical specialists) would both fall. The overall indication was that the Veterans Health Administration would position itself—using this authority—to make itself a more attractive employment opportunity for specialists, and that specialists would respond.

One of the requirements of the Act is that VA submits a report to the Committee 18 months post enactment, reporting its effects on recruitment and retention. We hope VA will address at least some of these questions in providing that report to the Committee.

In monitoring implementation of this legislation, we were disturbed at VA's exclusionary approach to developing compensation panels, setting parameters for market pay and establishment of performance pay incentives. We have learned that VA would not allow outside consultation with labor organizations representing VA physicians on any of these matters, despite the stated intention of your Committee that VA physicians be consulted in establishing these policies. Also, funding shortages in VA facilities essentially negated the promise of significant performance pay being made available to fulfill the purposes of the Act. In a number of networks, local management was given the option of setting arbitrary caps on performance pay that were imposed universally and preventing any significant rewards for outstanding performance, while VA physicians working within the performance plans were penalized if they failed to meet those expected levels of productivity. We understand that the American Federation of Government Employees was refused in its effort under the Freedom of Information Act to obtain statistical information from VA dealing with the establishment of compensation panels, the policies governing that work, and of salary ranges those panels set, even though it is difficult for us to understand the claimed "sensitive" nature of this information.

For all these reasons, The Independent Budget Veterans Service Organizations are concerned about the status of VA physician pay as a consequence of enactment of Public Law 108–445, and we hope the Committee will use its oversight authority to closely monitor VA actions.

THE INDEPENDENT BUDGET RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG, RANKING MEMBER, U.S. SENATOR FROM IDAHO

Question 1. The IB's recommendation of 9,300 direct FTE for the C&P service appears to be based on an assumption that VA will receive over 870,000 claims in Fiscal Year 2008 plus an additional 56,000 claims based on the six state outreach that occurred in 2006. VA, on the other hand, has estimated that it will receive 800,000 total claims in Fiscal Year 2008 and is not projecting any additional work in Fiscal Year 2008 based on the six state outreach, which ultimately generated only 8,000 additional claims.

Using the IB's math of 100 claims per FTE, if VA's projection of 800,000 claims is accurate, wouldn't the 8,300 direct FTE requested by the Administration be more than adequate?

Response. Yes, if VA's projection that it will receive 800,000 claims is accurate, 8,300 FTE would be adequate based on the IB recommendation of 100 claims per FTE. However, the IB is confident that its projection of more than 870,000 future claims receipts is more precise. The disability claims workload from returning war veterans and veterans of previous periods has steadily increased since 2000. During both Fiscal Year 2005 and Fiscal Year 2006, the total number of compensation, pension, and burial claims increased by an average annual rate of 4.5 percent. During this same period, the number of pending claims increased by a total of more than 33 percent. With an aging veterans population and ongoing hostilities in Iraq and Afghanistan, it is reasonable to expect a continuation of inclined rates. Assuming the annual percentage rate of growth remains the same as in preceding years, VA can expect 874,136 claims for C&P in Fiscal Year 2007. However, the VA perspective is that a slight decrease in the number of claims receipts will occur during 2007 and 2008. This prediction is somewhat troubling, considering that the VA funding shortfall that occurred in 2005 was attributed to error in estimating the number of future claims receipts.

Question 2. You recommend a 63 percent increase for the Veterans Benefits Administration, an increase of $737 million. I see that you propose $115 million for information technology initiatives, but it would appear that what remains is far too high to account for the extra staffing you propose (assuming an average cost of $85,000 for one FTE according to VA's budget documents) and for general inflationary increases.

Please explain how you arrived at your recommended increase for VBA.

Response. The Independent Budget recommendations for the Veterans Benefits Administration for Fiscal Year 2008 are significantly higher than the previous year primarily because our baseline from which we began our calculations was significantly higher than what appears to be the appropriated level in H.J. Res. 20. We do not believe that the current services level (appropriated level) adequately addressed the true needs and problems facing VBA. In fact, we believe that this level was wholly inadequate. The Fiscal Year 2007 appropriated level only allows the VA to barely keep its head above water. It does nothing to actually allow the VBA to reduce the backlog that it is dealing with. Not only that, the backlog is actually growing. It makes no sense to say that the Fiscal Year 2007 appropriated level is sufficient as a baseline to determine what will be needed to address the claims workload next year. The Independent Budget's Fiscal Year 2008 recommendations reflect what we believe it will take for the VBA to meet the needs of current and future veterans and actually start making progress on the claims backlog, and not just get by, as has been the case for many years. That accounts for the largest difference in our recommendations. The Independent Budget believes that the current baseline does not provide the VBA with a reasonable starting point to address the rapidly growing claims backlog.

From that starting point, the bulk of the increase in our recommendation comes from an increase in the compensation and pension (C&P) line item. Based on our calculations, inflationary increases total approximately $105 million over the Fiscal Year 2007 projected appropriation. Our compensation and pension recommendation also includes nearly $143 million for additional FTEE. This is derived from our estimated C&P average salary and benefits of approximately $100,000 for an additional 1,375 new FTEE. Finally, as you mention, our C&P increase includes the $115 million for the information technology initiatives. This accounts for our total increase in C&P over what we believe the available amounts will be from the appropriations bill.

The remaining increase in VBA is through inflationary increases to the primary accounts and modest increases in FTEE for Vocational Rehabilitation and Education.

Question 3. The Independent Budget proposes a $500 million initiative to expand mental health services, with a specific emphasis on PTSD care.

Please discuss briefly with us what you see as VA's shortcomings in mental health treatment and what you see the $500 million increase in services doing to fill the gaps your organizations have identified.

Response. As reported in the Fiscal Year 2008 Independent Budget, we are generally pleased with the direction VA has taken and the progress it has made with respect to implementing the National Mental Health Strategic Plan (MHSP). However, we assert that gaps remain in mental health services that still need to be addressed. The additional funding that we recommended is not intended to be earmarked for specific mental health programs, but instead is meant to boost the VA's efforts to adapt to the emerging and often unique needs of the newest generation of combat service personnel while continuing to address the chronic and acute needs of older veterans. We view this funding as necessary above the projected current services amounts that the VA will devote to the mental health care needs of these men and women.

Some additional insight on this issue from the perspective of The Independent Budget is necessary. In November 2006, the Government Accountability Office (GAO) issued a report on resources allocated for VA's MHSP initiatives. The GAO found that VA did not allocate all of the funding it planned in Fiscal Year 2005 for new mental health initiatives to address identified gaps in mental health services. Additionally, the GAO reported that the VA Central Office did not inform Veterans Integrated Service Network (VISN) and medical center officials that certain funds were to be used for these specific mental health initiatives, and therefore it is likely some funds went for other health care priorities. It is unacceptable that funding priorities that were clearly outlined were not properly managed, particularly at the VISN and lower levels.

Furthermore, VA has intensified its outreach efforts to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and reports that the relatively high rates of health care utilization among this group reflect the fact that these veterans have ready access to VA health care, which is available without charge for 2 years following separation from service for problems related to their wartime service. With increased outreach, internal mental health screening efforts now underway and expanded access to health care for OEF/OIF veterans, we are concerned that VA continues to underestimate the numbers of these veterans who will be seen for various mental health problems in VA facilities. This in itself could result in a shortfall in funding necessary to meet the demand. Additionally, VA has not yet developed an appropriate screening tool or treatment plan for veterans with mild traumatic brain injury (TBI). VA mental health providers believe they are ill-prepared to properly access, diagnosis and treat these types of patients in a multi-disciplinary manner, and that a strategic TBI plan should be developed and implemented immediately.

Finally, although VA has improved access to mental health services at its 800-plus community-based outpatient clinics (CBOCs), such services are still not readily available at all sites. Neither has VA yet achieved its goal of integrating mental health staff in all its primary care clinics. Also, we remain concerned about the capacity in specialized post-traumatic stress disorder (PTSD) programs and the decline in availability of VA substance-use disorder programs of all kinds, including the virtual elimination of inpatient detoxification and residential treatment beds.

Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and consequent rationed access to, the specialized services they provide.

FEBRUARY 12, 2007.

Hon. DANIEL K. AKAKA,
Chairman, U.S. Senate Committee on Veterans' Affairs,
Russell Senate Office Building,
Washington, DC.

Dear MR. CHAIRMAN: You have been advised of an opinion by Mr. Joseph A. Violante that opposition to the right legal representation in VA claims process exists. See: page 9 of his statement of February 13, 2007, to the Committee. I write to state the reason that opposition exists, how it is factually wrong and how Mr. Violante's statement is rife with an internal inconsistency. Once that is understood, I submit the wisdom of *permitting*, not "forc[ing]," as he repeatedly argues, veterans to obtain a private attorney will be quite apparent.

Opposition to the right to obtain legal counsel in the claims process is, I submit, based on a desire to maintain the status quo where DAV and a few other VSOs have a virtual monopoly on representation of veterans until the final BVA decision. To be sure, there is and has been a large cadre of lay representatives who for years have done good work on behalf of veterans. That has changed. Coupled with the inability of lay veteran service officers to cope with the increase in the volume of claims, the claims process has become very complex, indeed as complex as personal injury tort litigation. It may be argued, with some validity, that the advent of judicial review was, to some extent responsible. The fact remains the benefits system is complex, over burdened and understaffed including lay veteran service officers. As I said in my letter of last year to the then Chairman of this Committee, there is more than enough room for VSO and attorney representation in the claims process.

Mr. Violante laments, and probably correctly, "that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromise decisions and, higher appeal rates and even more overload on the system." Id. at p. 9. He also notes that the Inspector General's survey of the VBA adjudicators revealed that "nearly half of the VBA adjudicators admitted that many claims are decided without adequate record development." Id. My years on the Court convince me that he is correct. How then can it be validly argued as he does, that "adding attorneys to the claims system will only complicate, lengthen and make more fractious the resolution of veterans disability claims"? He simply asserts he has "been advised by professionals in the VBA" as to this conclusion. It is a highly dubious conclusion, and a self serving and convenient viewpoint. The professional obligations of lawyers, which is an enforceable duty, is to ensure an adequate record is compiled and presented, a thorough analysis of statutory and regulatory rights and duties is formulated and argued to the adjudicator which will bring the claim to issue for decision. That duty is the antithesis of fractioness. I add that since the Court's creation a national bar of competent attorneys has arisen. It is governed by disciplinary mechanisms which are lacking in the VSO scheme.

I close with this observation: In our society today, everyone but veterans with claims is free to have lawyer representation, and they are wise to seek it given our system of rights and duties. Even a convicted felon is entitled to counsel, as is a Social Security claimant. Why should veterans be deprived of the right everyone else has? Veterans are no longer deemed wards of the state requiring protection from historically perceived predators possessed only of self interest. They should be entitled to representation of their choice.

I implore this Committee to leave the right to select representation at the NOD stage as was enacted in the last Congress as a first step to permitting that choice to extend to the initial claims level.

Sincerely,

FRANK Q. NEBEKER,
Chief Judge (Retired).

FEBRUARY 13, 2007.

Hon. DANIEL K. AKAKA,
Chairman, Senate Committee on Veteran's Affairs,
Russell Senate Office Building,
Washington, DC.

Dear MR. CHAIRMAN: Written testimony has been submitted by the Disabled American Veterans (DAV) for February 13 hearing on the FY 2008 budget. In that written testimony, the DAV representative addresses, at pp. 9–10 the issue of attorneys in VA claims.

Last year, in Public Law 109–461, Congress specifically provided that veterans would be permitted the option to retain counsel for representation in the claims process at the departmental level. In the testimony submitted for the February 13 hearing, the DAV advocates repeal of that provision of Public Law 109–461.

As General Counsel of the Veterans' Administration (1985–1990), Acting General Counsel of the Department of Veterans Affairs (1990), and as a judge on the U.S. Court of Appeals for Veterans Claims (1990–2005; Chief Judge 2004–2005), I have been heavily engaged in the ongoing debate regarding judicial review. During that period, I have witnessed many changes in the veterans' claims system and I have developed a full appreciation of the needs of veterans and the strengths and weaknesses of the veterans' claims system. I am also a Vietnam veteran with 5 years active duty and retired after almost 25 years of active reserve duty in the U.S. Army.

In advocating repeal, the DAV states its belief that, "no disabled veteran should be forced to retain a private attorney." That statement is without basis in the context of Congress' purpose in permitting veterans, if they so choose, to retain attorney representation at the departmental level. The DAV goes on to state, without identifiable support, that, "your adding attorneys to the claims system will only complicate, lengthen and make more fractious the resolution of veterans' disability claims." This is an argument that was made in the late 1980s in opposition to the Veterans Judicial Review Act which created the Court of Veterans Appeals, now the United States Court of Appeals for Veterans Claims. That argument, at that time, became a non-negotiable political position on the part of the VA and a number of veterans' organizations. It is no longer a valid position, as evidenced by the actions of the last Congress and by the fact that the provision in Public Law 109–461 had substantial support from veterans' groups.

The Honorable Frank Q. Nebeker, the first Chief Judge of the U.S. Court of Appeals for Veterans Claims, in a letter to you regarding this subject, points out the weak and misleading nature of the DAV testimony and also points out that, although veterans have had the benefit of judicial review for more than 16 years, until the last Congress, "everyone but veterans with claims is free to have lawyer representation." I repeat his question to you: "Why should veterans be deprived of the right everyone else has?"

I strongly urge you and the Members of the Committee to resist any attempt to repeal the provisions of Public Law 109–461 granting veterans the option to retain an attorney to represent them at the VA level.

Sincerely,

DONALD L. IVERS,
Chief Judge (Retired),
U.S. Court of Appeals for Veterans Claims.

LUNG CANCER ALLIANCE,
Washington, DC, March 22, 2007.

Hon. DANIEL K. AKAKA,
Chair, U.S. Senate Committee on Veterans' Affairs,
Senate Russell Building,
Washington, DC.

DEAR MR. CHAIRMAN: As Chairman of the Board of Directors of Lung Cancer Alliance I would like to express our strong support for The Independent Budget and would appreciate this letter being included in the Committee's hearing record on the FY08 budget for the Veterans' Administration.

In particular we would like to bring to your Committee's attention the recommendation in The Independent Budget for a $3 million Lung Cancer Early Detection and Disease Management Research Pilot program, a copy of which is attached to this letter for inclusion in the hearing record.

As a longtime VSO and lung cancer patient, I am concerned with the plight of all Veterans at risk for this disease. Lung cancer kills more Americans than the next five cancers combined. Repeated studies have shown that Veterans, for a host of reasons, die of lung cancer at a greater rate than their fellow Americans who did not serve. I believe that the Department of Veterans Affairs will be facing a wave of service connected lung cancer victims as Vietnam Veterans enter their sixties when the disease most commonly presents.

This is a stealth cancer that usually takes decades to develop. By the time symptoms do become apparent, the disease is already at late stage. Currently, only 16 percent of cases are diagnosed at an early stage when the cancer is curable. For the taxpayer and the VA, the benefits to screening are economic as well as humanitarian: it costs half as much to treat someone in Stage One as it does to treat a late stage lung cancer patient. The alternatives are clear: pay now and save lives, or pay double for dying patients.

The relatively small investment of $3 million in a pilot early detection research program gives Congress and the Department an extraordinary opportunity to get ahead of the problem, saving dollars and lives in the process. No one contests the fact that CT scanning can detect lung cancer at its earliest stage.

Several long term, large population trials have demonstrated that the current 85 percent mortality rate can be reversed through early detection and treatment. While more studies and trials are underway, it is imperative that at a minimum a pilot research program be simultaneously carried out among a high risk Veteran population.

I urge the Committee to include this pilot research program in the FY08 budget authorization and appropriations for the Department of Veterans Affairs.

Respectfully,

PHILIP J. COADY,
Rear Admiral, USN (Retired),
Chairman of the Board, Lung Cancer Alliance.

LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PILOT PROGRAM

More than 50 percent of new lung cancer cases are diagnosed in former smokers, including many who had quit 20 or 30 years ago. Another 15 percent of new lung cancer cases occur in people who have never smoked, with possible causes including radon, asbestos, Agent Orange and other herbicides, beryllium, nuclear emissions, diesel fumes, and other toxins.

Over the next six years, one million Americans will die from lung cancer, most within months of diagnosis. It is the leading cause of cancer death, responsible for nearly 30 percent of all cancer mortality, more than breast, prostate, colon, liver, melanoma, and kidney cancers combined.

Since Congress passed the National Cancer Act in 1971, the five-year survival rates for breast, prostate, and colon cancers have risen to 88 percent, 99 percent, and 65 percent respectively, primarily because of major funding investments in research and early detection for those cancers. Lung cancer's five-year survival rate is still at 15 percent, reflective of the persistent underfunding of research and early detection. Lung cancer now kills three times as many men as prostate cancer and nearly twice as many women as breast cancer.

• *Impact on Military and Veteran Populations*

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarette packages in K-rations until 1976. The 1997 Harris report to the Department of Veterans Affairs (VA) documented the higher prevalence of smoking and exposure to carcinogenic materials among the military and estimated costs to VA and TRICARE in the billions of dollars per year. For example, the percentage of Vietnam veterans who ever smoked is more than 70 percent, double the civilian "ever smoked" rate of 35 percent. Asbestos in submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are additional factors that have led to a 25 percent higher incidence and mortality rate for lung cancer among veteran populations.

A 2004 report by the Board on Health Promotion and Disease Prevention (HPDP) of the Institute of Medicine (IOM), "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer (2004)," concluded that the presumptive period for lung cancer is 50 years or more. Another report issued in 2005 by the HPDP, "The Gulf War and Health: Volume 3, Fuels, Combustion Products and Propellants (2005)," concluded that there is sufficient evidence for an association between battlefield combustion products and lung cancer.

Lung cancer is an indolent cancer that takes decades to develop, and in most cases no symptoms present until the cancer is already at late stage. Thus, while the disease may initiate under circumstances encountered during service under the DOD, the disease burden will fall most heaavily on VA, and to a lesser extent on TRlCARE. Because of the predominance of late stage diagnoses, more than 60 percent of lung cancer patients die within the first year, and late stage treatment is more than twice as costly as early stage.

• *Justification*

On October 26, 2006, the New England Journal of Medicine published the results of a l3-year study on CT screening of 31,500 asymptomatic people by a consortium of 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at stage 1 (versus 16 percent nationally) and the estimated 10-year survival rate for those treated promptly is 92 percent (versus a 15 percent 5-year survival rate nationally).

The benefits of this early detection and disease management protocol should be extended to veterans, especially those whose active duty service has placed them at higher risk for lung cancer.

• *Legislative History*

Senate Report 108–087 on the Department of Defense Appropriations Bill, 2004 contains the following language:

"Lung Cancer Screening—The Committee' urges the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to begin a multi-institutional lung cancer screening program with centralized imaging review incorporating state-of-the-art image processing and integration of computer assisted diagnostic tools."

Senate Report 109–286, Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2007 contains the following language:

"Lung Cancer Screening—The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on a proposal for this program."

• *Department of Energy (DOE) and Lung Cancer*

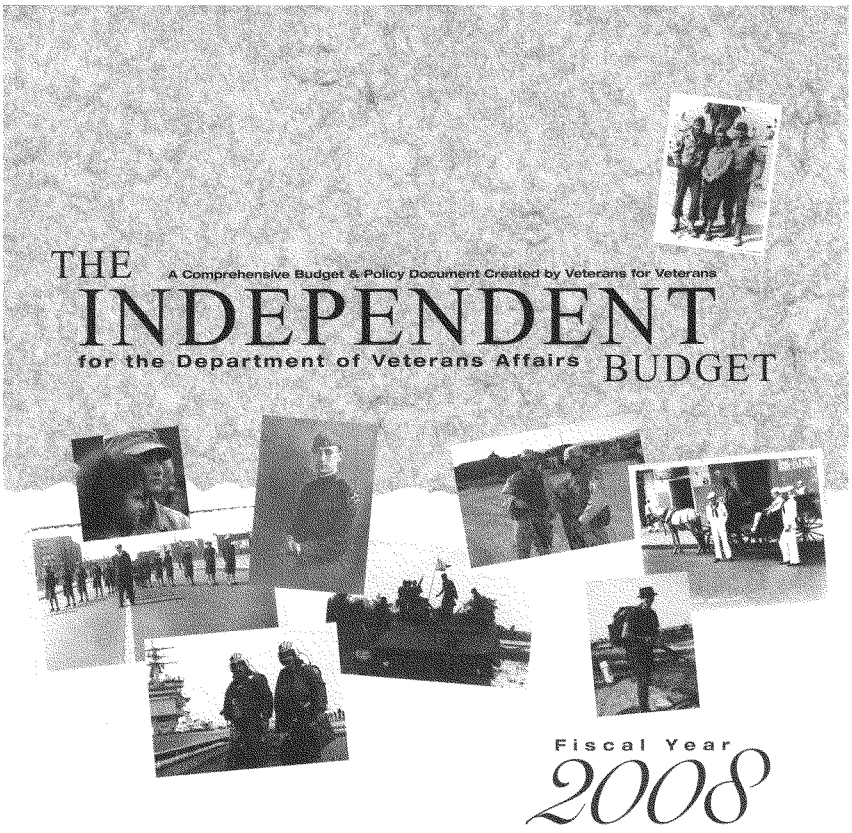
Over the past eight years the DOE Office of Environment, Safety and Health has supported a medical screening program for DOE defense nuclear workers who were exposed to toxic and radioactive substances. The Worker Health Protection Program was originally authorized under Section 3162 of the 1993 Defense Authorization Act and has been funded through DOE appropriations. Currently more than 7,000 workers at seven different munitions plant sites are being screened free of charge annually for lung cancer. In FY 06, funding was increased to $14 milllon to cover an expansion of sites and the number of participants.

RECOMMENDATIONS

VA should request and Congress should appropriate at least $3 million to conduct a pilot screening program for veterans at high risk of developing lung cancer.

VA should partner with the International Early Lung Cancer Action Program to provide early screening of veterans at risk.

[The Independent Budget for Fiscal Year 2008 follows:]


THE
A Comprehensive Budget & Policy Document Created by Veterans for Veterans
INDEPENDENT
for the Department of Veterans Affairs
BUDGET
Fiscal Year
2008

VA Accounts FY 2008

	FY 2007 Appropriation**	FY 2008 Admin	FY 2008 IB
Veterans Health Administration			
Medical Services	25,512,000	27,167,671	28,979,220
Medical Administration	3,177,000	3,442,000	3,378,067
Medical Facilities	3,569,000	3,592,000	3,991,152
Total, Medical Care	**32,258,000**	**34,201,671**	**36,348,439**
Medical and Prosthetic Research	413,700	411,000	480,000
Subtotal, Veterans Health Administration	**32,671,700**	**34,612,671**	**36,828,439**
Veterans Benefits Administration	1,168,445	1,198,294	1,905,300
General Administration	312,319	273,543	328,541
Total, General Operating Expenses (GOE)	**1,480,764**	**1,471,837**	**2,233,841**
Information Technology	1,213,820	1,859,217	1,340,098
National Cemetery Administration	160,733	166,809	218,335
Office of Inspector General	70,674	72,599	73,233
Subtotal, Dept. Admin. and Misc. Programs	**1,445,227**	**2,098,625**	**1,631,666**
Construction, Major	399,000	727,400	1,602,000
Construction, Minor	198,937	233,396	541,000
Grants for State Extended Care Facilities	85,000	85,000	150,000
Grants for Construction of State Vets cemeteries	32,000	32,000	37,000
Subtotal, Construction Programs	**714,937**	**1,077,796**	**2,330,000**
Other Discretionary	154,158	155,501	158,629
Subtotal, Discretionary	**36,466,786**	**39,416,430**	**43,182,575**
Cost for Category 8 Veterans Denied Enrollment			**365,977**
Total, Discretionary			**43,548,552**

****FY 2007 Appropriations Amounts Based on H.J.Res. 20, Continuing Resolution for FY 2007**

Prologue

This is the 21st year *The Independent Budget (IB)* has been developed by four veterans service organizations: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

The *IB* is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans to be laid to rest in our national and state veterans cemeteries.

The President has stated that the war on terrorism is likely to be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends.

With this new reality ever present in our minds, we must do everything we can to ensure that VA has all the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a country that not only cherishes their service but also honors them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome the employment challenges created by injury, and the best claims processing system to deliver education, compensation, and survivors' benefits in a minimum amount of time to those most harmed by their service to our nation.

It is fitting that our 21st *Independent Budget* comes early in the 21st century. *The Independent Budget* veterans service organizations, or IBVSOs, work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

This year, as in the past, we call on Congress to find a better way to fund veterans' health-care spending by removing the veterans' budget from the battle over annual discretionary spending. We call on Congress to establish a formula to provide VA health-care funding from the mandatory side of the federal budget, ensuring an adequate and timely flow of dollars to meet the needs of sick and disabled veterans.

Tom McGriff
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FY 2008 *INDEPENDENT BUDGET* SUPPORTERS

AAALAC International
Administrators of Internal Medicine
African American Post Traumatic Stress Disorder
Air Force Association
Air Force Women Officers Association
Alliance for Academic Internal Medicine
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Veterans Alliance, USA
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Subspecialty Professors
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Christopher Reeve Foundation
Clerkship Directors in Internal Medicine
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
FOVA
Georgia Department of Veterans Affairs
Gold Star Wives of America, Inc.
Iraq & Afghanistan Veterans of America
Japanese American Veterans Association
Jewish War Veterans of the USA

continued on next page

Lung Cancer Alliance
Mental Health America
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Health
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of County Veterans Service Officers
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Gulf War Resource Center, Inc.
National Organization on Disabilities
National Spinal Cord Injury Association
Naval Reserve Association
Navy Club of the United States of America
Navy Seabee Veterans of America
Non Commissioned Officer Association
P-47 Thunderbolt Pilots Association
Nurses Organization of Veterans Affairs
State of Washington
The Forty & Eight
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Organization
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.
- VA's mission to conduct medical and prosthetic research in areas of veterans' special needs is critical to the integrity of the veterans' health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

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Introduction

As *The Independent Budget* begins its third decade, we are faced with predicting the needs of an ever-growing veterans population in the midst of a war. Even as the Department of Veterans Affairs (VA) continues to deny many veterans access to health care, many more men and women who have sacrificed themselves in the global war on terrorism are taking advantage of the VA health-care and benefits system. Unfortunately, the task of estimating the true resource needs for the VA to carry out a responsible budget has been significantly complicated by a lack of action on the part of Congress in 2006.

Yet last year proved to be a unique year for reasons very different from 2005. After the budget shortfall debacle that occurred in 2005, the Administration submitted a budget request last year for FY 2007 that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again. These recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans. We are proud that more than 50 veterans, military, and medical service organizations have endorsed the 21st edition of *The Independent Budget* this year.

As our nation's service members continue to be placed in harm's way in conflicts around the world, it is important that their needs upon returning home from the battlefield are met. The VA health-care and benefits system is a critical national resource for our nation's increasing veteran population. Veterans depend on VA for the health-care, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. As the Administration and Congress consider the monetary needs of VA this fiscal year, they should pause to consider how much is at stake.

Year after year, we call on Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, VA remains underfunded and unable to provide timely access to quality health care to many of our nation's veterans. A system praised for the work it does is held hostage by the very people charged with the responsibility of meeting veterans' needs. If Congress cannot fulfill its solemn obligation to these men and women through the current process, it is only appropriate that the VA health-care system be made mandatory funding. Mandatory funding would ensure that the government meets its obligation to ensure all veterans eligible for VA health care have access to timely, quality care.

With regard to veterans' benefits, *The Independent Budget* recognizes a vastly growing crisis that has not been properly addressed in years past. It is time to take real steps to fix the backlog in claims processing before the system collapses under its own weight. Continuing to study these problems without developing real solutions serves no other purpose than to delay

the benefits that veterans have earned and deserve. Moreover, a large number of adjudication decisions are incorrect or have technical or procedural errors, further exacerbating the problem. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The Independent Budget covers the broadest spectrum of veterans' benefits and services with recommendations on each to make certain we keep the nation's obligation to those who have served and sacrificed so much in its defense. We understand that veterans' health care and benefits cost a lot of money, but these are men and women who have paid the price. They have taken the oath and served this country with honor and distinction. It is time that the promises made to them are promises kept.

VA Accounts FY 2008

(Dollars in Thousands)

	FY 2007 Appropriation**	FY 2008 Admin	FY 2008 IB
Veterans Health Administration			
Medical Services	25,412,000		28,979,220
Medical Administration	3,277,000		3,378,067
Medical Facilities	3,594,000		3,991,152
Total, Medical Care	**32,283,000**	**0**	**36,348,439**
Medical and Prosthetic Research	412,000		480,000
Subtotal, Veterans Health Administration	**32,695,000**	**0**	**36,828,439**
Veterans Benefits Administration	1,167,859		1,905,300
General Administration	312,905		328,541
Total, General Operating Expenses (GOE)	**1,480,764**	**0**	**2,233,841**
Information Technology	1,302,330		1,340,098
National Cemetery Administration	160,733		218,335
Office of Inspector General	69,499		73,233
Subtotal, Dept. Admin. and Misc. Programs	**1,532,562**	**0**	**1,631,666**
Construction, Major	283,670		1,602,000
Construction, Minor	210,000		541,000
Grants for State Extended Care Facilities	105,000		150,000
Grants for Construction of State Vets Cemeteries	32,000		37,000
Subtotal, Construction Programs	**630,670**	**0**	**2,330,000**
Other Discretionary	154,158		158,629
Subtotal, Discretionary	**36,493,154**	**0**	**43,182,575**
Cost for Category 8 Veterans Denied Enrollment			365,977
Total, Discretionary			**43,548,552**

***FY 2007 Appropriations Amounts Based on Figures Provided in H.R. 5385*

Benefit Programs

Through the Department of Veterans Affairs (VA), our citizens provide a wide array of vital benefits to veterans. Included are disability compensation, dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments fulfill our primary obligation to make up for the economic and other losses veterans suffer as a result of the effects of service-connected diseases and injuries. When veterans' lives are cut short by service-connected injuries or following a substantial period of total service-connected disability, eligible family members receive DIC. Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes or who have attained the age of 65. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly financial allowance, health care and vocational rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide financial assistance to veterans in education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available for children and spouses of veterans who are permanently and totally disabled or for those who die as a result of service-connected disability. Qualifying students pursuing VA education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

Under its home loan program, VA guarantees commercial home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible Reservists and National Guard members. VA also makes direct loans to supplement specially adapted housing grants. VA makes direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members

of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

Through collaborative efforts of Congress, VA, and veterans service organizations, VA benefit programs have been carefully crafted. Experience has proven that they generally serve their intended purposes and taxpayers very well. Over time, however, we learn of areas in which adjustments are needed to make the programs better serve veterans or to meet changing circumstances. Unfortunately, failure to regularly adjust the benefit rates for increases in the cost of living or to make other needed changes erodes the value and effectiveness of some veterans' benefits.

Veterans' programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. To maintain or increase their effectiveness, we offer the following recommendations.

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Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

Congress should provide a cost-of-living adjustment (COLA) for compensation benefits.

Veterans whose earning power is compromised or completely lost as a result of service-connected disabilities must rely on VA compensation for the necessities of life. Similarly, surviving spouses of veterans who died of service-connected disabilities often have little or no income other than dependency and indemnity compensation (DIC). Compensation and DIC rates are modest, and any erosion due to inflation has a direct and detrimental impact on recipients with fixed incomes. Therefore, these benefits must be adjusted periodically to keep pace with increases in the cost of living. Observant of this principle, Congress has traditionally adjusted compensation and DIC rates annually.

RECOMMENDATION:

Congress should enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.

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Full Cost-of-Living Adjustment for Compensation:

To maintain the effectiveness of compensation for offsetting the economic loss resulting from service-connected disability and death, Congress must provide cost-of-living adjustments (COLAs) equal to the annual increase in the cost of living.

Disability compensation and dependency and indemnity compensation (DIC) rates have historically been increased each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break its recurring habit of extending this round-down provision and has extended it even in the face of prior budget surpluses. Inexplicably, VA budgets have recommended that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for one or two years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended—and certainly permanent—rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and their dependents and survivors, who must rely on their modest VA compensation for the necessities of life.

RECOMMENDATION:

Congress should reject any recommendations to permanently extend provisions for rounding down compensation COLAs and allow the temporary round-down provisions to expire on their statutory sunset date.

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Standard for Service Connection:

Service-connected benefits should be provided for all disabilities incurred or aggravated in the line of duty.

The core veterans' benefits are those provided to make up for the effects of "service-connected" disabilities and deaths. When disability or death results from an injury or disease incurred or aggravated in the "line of duty," the disability or death is service-connected for purposes of entitlement to these benefits for veterans and their eligible dependents and survivors. A disability or death from injury or disease is in the line of duty if incurred or aggravated "during" active military, naval, or air service, unless it is due to misconduct or other disqualifying circumstances. Accordingly, a disability or death from an injury or disease that occurs or increases during service meets the current requirements of law for service connection.

These principles are expressly and clearly set forth in current law. Under the law, the term "service-connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term, "active military, naval, or air service," contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the armed forces of the United States.

A member on active duty in the armed forces is at the disposal of military authority and, in effect, serves on duty 24 hours a day, 7 days a week. Under many circumstances, such member may be directly engaged in performing tasks involved in his or her military vocation for far more extended periods than a typical eight-hour civilian workday and may be normally on call or standing by for duty the remainder of the hours in a day. Under other typical circumstances, a service member may live on or near the workstation 24 hours

a day, such as when on duty on submarine, ship, or remote military outpost. Even when a military service member is not actively or directly engaged in performing functions of his or her military occupational specialty, the member is indirectly on duty or involved in general military duties and ongoing responsibilities associated therewith. In America's military service, there is no distinction between on duty and off duty for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there are rigors, physical and mental stresses, and known and unknown risks and hazards unlike, and far beyond, those seen in civilian occupations and daily life. American military service members stationed overseas are often exposed to increased risks of injury and disease, both on and off military facilities.

For these reasons, current law requires only that an injury or disease be incurred or aggravated "coincident with" military service; there is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought. For these same reasons, a requirement to prove service causation would be unworkable as long as it remains the purpose of the law to equitably dispose of questions of service connection and provide benefits when benefits are rightfully due those who risk their health and lay their lives on the line to bear the extraordinary burdens of defending our national interests, often in terrible hardship and risk of life. Of course, if it were to become the object of our government to limit as much as possible its responsibility for veterans' disabilities rather than to have a fair and practical legal framework for justice for them, requiring proof of service causation would accomplish that object effectively by making it more difficult to prove otherwise meritorious claims for compensation.

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be granted unless a veteran could offer proof that a disability was caused by the actual performance of military duty. Although this scheme was not enacted into law, the final legislation did require the establishment of a federal advisory commission to study the foundations of disability benefit programs for veterans—presumably with the same ultimate goal in mind. This action seems to be consistent with current systematic efforts to reduce spending on military personnel and veterans' programs in order to devote more resources to mission programs, personnel, weapons and other military hardware, and the operational costs of war.

The Independent Budget veterans service organizations believe that current standards governing service connection for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations urge Congress to reject any revision of this longstanding policy standard for the purpose of permitting the federal government to coldly and expediently avoid its responsibilities for the human costs of war and our national defense.

RECOMMENDATION:

Congress should reject any suggestion from any source to change the terms for service connection of veterans' disabilities and deaths.

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Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and Department of Veterans Affairs (VA) disability compensation concurrently.

Some former service members who are retired from the armed forces on the basis of length of service must forfeit a portion of the retired pay they earned through faithful performance of military service to receive VA compensation for service-connected disabilities. This is inequitable because military retired pay is earned by virtue of a veteran's long service on behalf of the nation.

Entitlement to compensation, on the other hand, is for an entirely separate reason—because of disability incurred during that military service. Most nondisabled military retirees pursue second careers after serving, in order to supplement their income, thereby justly enjoying a full reward for completion of a military career along with the added reward of full pay in civilian employment. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. To put them on equal footing with nondisabled military retirees, disabled retirees should receive full military retired pay and compensation, to account for diminution of their earning capacities.

To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than a nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing the enlistment obligation can receive full VA compensation and full civilian retired pay—including retirement from federal civil service employment and employment in the U.S. Postal Service. A veteran who has served this country in the armed forces for 20 years or more, however, or one who was disabled and discharged before attaining the full military retirement service threshold, should have that same right. A disabled veteran should not suffer a financial penalty for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of VA disability compensation otherwise payable, our government is in effect compensating the veteran with *nothing* for the service-connected disability he or she suffered. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

RECOMMENDATION:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay, based on longevity, be offset by an amount equal to their rightfully earned VA disability compensation.

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Continuation of Monthly Payments for all Compensable Service-Connected Disabilities:

Lump-sum settlements of disability compensation should not be used as a way to decrease the government's obligation to disabled veterans and save the government money.

Under current law, the government pays disability compensation monthly to eligible veterans on account of, and at a rate commensurate, with diminished earning capacity resulting form the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, VA would use the immediate availability of a lump-sum settlement to entice veterans to bargain away their future entitlement. Such lump-sum payments would not be, on the whole, in the best interests of disabled veterans, but rather would be for government savings and convenience. *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

RECOMMENDATION:

Congress should reject any recommendation that it change the law to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

▼ ▼ ▼

Increase in Rates of Special Monthly Compensation:

Congress should increase rates of payment to veterans suffering from service-connected disabilities who are determined housebound or in need of regular aid and attendance because of these service-incurred disabilities.

The Department of Veterans Affairs, under the provisions of title 38, United States Code, section 1114(k) through (s), provides additional special compensation to select categories of veterans with very severe, debilitating disabilities, such as the loss of a limb, loss of certain senses, and to those who require the assistance of an aide for the activities of daily living, such as dressing, toileting, bathing, and eating.

A veteran who, as the result of a service-connected disability, has suffered the anatomical loss of use of a creative organ, or one foot, or one hand, or both buttocks, or blindness of one eye having only light perception, or who has suffered complete organic aphonia with constant inability to communicate through speech, or deafness of both ears having absence of air and bone conduction, and, in the case of a woman, the anatomical loss of one or both breasts (including loss by mastectomy), the rate of special compensation is at present $84 per month for each such devastating loss, or loss of use, beyond the service-connected compensation level of disability granted.

The payment of special monthly compensation, while minimally adjusted for inflation each year, is now no longer sufficient to compensate for the special needs of these veterans.

RECOMMENDATION:

Congress should enact legislation to increase the special monthly compensation under title 38, United States code, section 1114(l) through (s) by an immediate 20 *percent* above the current base amount and additionally, increase by 50 *percent* the current base amount of special monthly compensation under title 38, United States Code, Section 1114(k).

More Equitable Rules for Service Connection of Hearing Loss and Tinnitus:

For combat veterans and those who had military occupations that typically involved noise exposure sufficient to cause hearing loss or tinnitus, service connection should be presumed.

Many combat veterans and veterans that had military duties involving high levels of noise exposure who now suffer from hearing loss or tinnitus likely related to noise exposure or acoustic trauma during service are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor record-keeping.

In a September 2005 report, "Noise and Military Service: Implications for Hearing Loss and Tinnitus," the Institute of Medicine found: "Patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel...Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial, but the available data provide no basis for a valid estimate of the number."

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged and frequent loud noises from unusual sources, such as the sound of gunfire and jet and other loud aircraft engines, just to name a few. Combat veterans are likely to have suffered acoustic trauma from black powder and other explosive sources. Exposure to loud noise and acoustic trauma are both known causes of high-frequency hearing loss and tinnitus. Yet, many combat veterans are unable to document that their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by spoken voice and whispered voice was insufficient to detect hearing loss in many instances.

Other veterans serve in military occupations that typically involve noise exposure sufficient to cause hearing loss. Today, ear protection is mandatory in these military occupations, but many performed the same jobs without protection during earlier periods.

With some regularity, audiometric testing or records of testing are insufficient or lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control and should do the same for combat veterans and veterans whose military duties are generally recognized (e.g., artillery gun crews) to have involved noise exposure sufficient to cause hearing loss and tinnitus. When these veterans suffer from tinnitus or the type of hearing loss that can result from noise exposure and when their medical records are insufficient to prove absence of service-related hearing loss or tinnitus during service, service connection should be presumed after reasonably ruling out any post-service causation.

RECOMMENDATION:

Congress should enact a presumption of service-connected disability for combat veterans and veterans who performed military duties typically involving high levels of noise exposure and who subsequently suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma. This presumption of disability should be applied when the veteran's record does not affirmatively prove such condition or conditions are unrelated to service.

Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

The Department of Veterans Affairs (VA) disability rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable rating for hearing loss at certain levels severe enough to require hearing aids. The minimum disability rating for any hearing loss warranting use of hearing aids should be 10 percent, and the schedule should be changed accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment itself and the disadvantages of artificial restoration of hearing, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device. For example, a veteran receives full compensation for amputation of a lower extremity although he or she may ambulate normally with a prosthetic limb. Providing a compensable rating for this condition would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

RECOMMENDATION:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability rating for any hearing loss for which the wearing of a hearing aid is medically indicated.

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Temporary Total Compensation Awards:

Temporary awards of total disability compensation should be exempted from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence.

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating of 100 percent. This rating is effective the first day of hospitalization and continues to the last day of the month of discharge from hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective the date of hospital admission or outpatient visit.

Although the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, the provisions of 38 U.S.C. § 5111 delay the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of any increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardships.

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38 C.F.R. §§ 4.29 4.30, from the provisions of title 38 U.S.C. § 5111.

RECOMMENDATION:

Congress should amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

Pension for Nonservice-Connected Disability:

Congress must amend basic eligibility for pensions for nonservice-connected veterans who serve in combat circumstances, irrespective of whether these are declared wars.

Many veterans who have participated in hostile military operations do not fall within any defined or declared period of war as currently listed in title 38, Code of Federal Regulations, paragraph 3.2. Accordingly, these veterans are ineligible for nonservice-connected war pension benefits under title 38, United States Code, Chapter 15, "Pension for Nonservice-Connected Disability/Death."

Some expeditionary medals and combat badges are awarded to members of the armed forces who have served deployments in hostile regions, situations and circumstances other than those officially designated combat operations, or during a wartime era as declared by Congress. These veterans may have served our nation under more dangerous and threatening circumstances than veterans who served during official periods of war and those who, while serving in a period of war, were not directly involved in combat or infantry operations.

RECOMMENDATION:

Congress should amend eligibility requirements in title 38, United States Code, Chapter 15, to authorize eligibility for nonservice-connected disability pension to veterans who have been awarded the Armed Forces Expeditionary Medal, the Navy/Marine Corps Expeditionary Medal, the Purple Heart, the Combat Infantryman's Badge, the Combat Medical Badge, or the Combat Action Ribbon for participation in military operations not falling within an officially designated or declared period of war.

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Dependency and Indemnity Compensation

Review of Adequacy of Overall Dependency and Indemnity Compensation Program:

Congress should review adequacy of dependency and indemnity compensation (DIC) to ensure the level of VA financial support is adequate to maintain these beneficiaries above the poverty level.

The VA Dependency and Indemnity Compensation program provides monthly financial support to the widow or widower of a veteran who dies from a service-connected disability (including the survivor of an active duty service member who dies while still in military service). Historically, DIC was intended to enable a survivor of a veteran to maintain a standard of living above the poverty level that might have ensued because of the loss of a spouse's life income and earning power. Current payment rates for DIC are set in law, and generally the maximum monthly payment is limited to $1,033, about 41 percent of the level of maximum service-connected disability payment to a totally disabled veteran—and considerably less than pensions paid to a survivor of a federal retiree, which is set in law at 55 percent of that federal annuity. Because of inflation and other economic factors, many widows (and some widowers) are in fact now living in poverty due to lack of income other than DIC. Their situations are often compounded by their own disabilities, child-care responsibilities, and consequent inability to work. *The Independent Budget* veterans service organizations feel strongly that no survivor of a veteran who died as a result of service-connected disability, and most certainly no survivor of a service member who died while serving our nation, ever should be reduced to poverty as a result of government compensation policy.

RECOMMENDATION:

Congress should use the General Accountability Office or another independent reviewer to examine the VA's DIC program to ensure that current policy adequately maintains the survivors of veterans who died as a result of service-connected disabilities and make legislative recommendations to Congress to correct any inequities observed from such examination.

Repeal of Offset Against Survivor Benefit Plan:

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of, and by an amount, equal to dependency and indemnity compensation (DIC) is inequitable.

A veteran disabled in military service in our armed forces is compensated for the effects of the service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the Department of Veterans Affairs. This benefit indemnifies survivors for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the SBP, deductions are made from the member's retired pay to purchase a survivors' annuity. This is not a gratuitous benefit. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected causes for the required time preceding his or her death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service-connected causes or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

RECOMMENDATION:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.

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Increase of DIC for Surviving Spouses of Service Members:

Congress should elevate rates of DIC to survivors of active duty military personnel who die while on active duty.

Current law authorizes the Department of Veterans Affairs to pay additional, enhanced amounts of dependency and indemnity compensation, in addition to the basic rate, to the surviving spouses of veterans who die from service-connected disabilities, after at least an eight-year period of the veteran's total disability rating prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of DIC.

Needless to say, this is inequitable because surviving spouses of deceased active duty service members face the same financial hardship as survivors of deceased service-connected veterans who were totally disabled for eight years prior to their deaths.

RECOMMENDATION:

We urge Congress to authorize DIC eligibility at increased rates to survivors of deceased military personnel on the same basis as that for the survivors of totally disabled service-connected veterans.

Retention of Remarried Survivors' Benefits at Age 55:

Congress should lower the age threshold for eligibility for restoration of dependency and indemnity compensation (DIC) to remarriage of survivors of veterans who die from service-connected disabilities.

Current law permits remarried survivors of veterans who die from service-connected disabilities to requalify for DIC benefits if the remarriage occurs at age 57 or older, or if already remarried, they apply for reinstatement of DIC at age 57. While *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is based on no objective data related to this population or its needs. Remarried survivors of retirees in other federal programs obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

RECOMMENDATION:

Congress should lower the existing eligibility age for reinstatement of DIC to remarried survivors of service-connected veterans, from 57 years of age to 55 years of age.

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READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Military service members who in every respect are at least equally entitled to participate in the Montgomery GI Bill as service members who first entered military service after June 30, 1985, are ineligible if they entered or had military service before that date.

Under current law, an active duty service member must have first become a member of the armed forces after June 30, 1985, to be eligible to participate in the Montgomery GI Bill. An active duty service member who entered active duty before that date and continues to serve cannot participate—unless he or she was enrolled in the prior educational assistance program and elected to convert to the Montgomery GI Bill when that opportunity was first offered. In this situation, service members who have served longer and are arguably more deserving of educational benefits are treated less favorably than members who have served in the armed forces for shorter periods.

Any person who was serving in the armed forces on June 30, 1985, or any person who reentered service in the armed forces on or after that date, if otherwise eligible, should be allowed to participate in the Montgomery GI Bill under the same conditions as members who first entered military service after that date.

RECOMMENDATION:

Congress should amend the law to remove the restriction on eligibility to the Montgomery GI Bill to those who first entered military service after June 30, 1985.

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Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

The government should refund the contributions of individuals who become ineligible for the Montgomery GI Bill because of general discharges or discharges "under honorable conditions."

The Montgomery GI Bill–Active Duty program provides educational assistance to veterans who first entered active duty (including full-time National Guard duty) after June 30, 1985. To be eligible, service members must have elected to participate in the program and made monthly contributions from their military pay. These contributions are not refundable.

Eligibility is also subject to an honorable discharge. Discharges characterized as "under honorable conditions" or "general" do not qualify. *The Independent Budget* veterans service organizations believe that in the case of a discharge that involves a minor infraction or deficiency in the performance of duty the individual should at least be entitled to a refund of his or her contributions to the program.

RECOMMENDATION:

Congress should change the law to permit refund of an individual's Montgomery GI Bill contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

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Matching Education Benefits to Service Performed— A 21st Century Montgomery GI Bill:

The nation's active duty, National Guard, and Reserve forces are operationally integrated under the Total Force policy. But educational benefits do not reflect the policy nor match benefits to service commitment.

Congress reestablished the GI Bill in 1984. The Montgomery GI Bill (MGIB) was designed to stimulate all-volunteer force recruitment and retention and to help veterans readjust to civilian life. Active duty veterans have up to 10 years post-service to use the MGIB. But Reservists who earn certain MGIB benefits during mobilization get no post-service use of those benefits. In the 1980s, policymakers and Congress never envisioned the routine use of Guard and Reserve forces for every operational mission, nor did many people perceive a need for a post-service readjustment benefit for Reserve participants. The Reserve MGIB worked well for the first 15 years of the MGIBs existence. Slippage of Reserve benefits in relationship to the active duty MGIB started at about the time that large and sustained call-ups of the Guard and Reserve began after the September 11, 2001, attacks. Congress attempted to respond to this benefit gap by authorizing a second Reserve Title 10 MGIB program—"Chapter 1607"—for reservists who were mobilized for more than 90 days for a contingency operation. However, the complexity of "Chapter 1607" program funding challenges, and the difficulty of correlating it with both the original Reserve MGIB—"Chapter 1606"—and the active duty program, have delayed its implementation, perhaps indefinitely.

The nation's total armed forces need a MGIB that supports recruitment and retention, readjustment to civilian life, proportionality of benefits for service rendered, and ease of administration.

The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be organized under title 38. (The responsibility for enlistment incentives, MGIB "kickers," and other incentives would remain with the Department of Defense under title 10.) Second, MGIB benefit levels should be simplified according to the military service performed.

To align benefits with service performed, National Guard and Reserve MGIB programs would be inte-

grated with the active duty program. Second, benefit rates would be structured as follows:

1. Tier one—similar to the current Montgomery GI Bill–Active Duty three-year rate—would be provided to all who enlist in the active armed forces. Service entrants would receive 36 months of benefits at the Active Duty Rate.

2. Tier two would be for nonprior service direct entry in the Selected Reserve (SELRES) for six years. Benefits would be proportional to the active duty rate. Historically, Selected Reserve Benefits have been 47 to 48 percent of active duty benefits.

3. Tier three would be for members of the Ready Reserve who are activated for at least 90 days. They would receive one month of benefits for each month of activation, up to a total of 36 months, at the active duty rate.

A service member would have up to 10 years to use remaining active duty or activated-service benefits—tier one and tier three—from the date of separation. A selected reservist could use remaining second tier MGIB benefits as long as he or she were satisfactorily participating in the SELRES and for up to 10 years following separation from the reserves if a separation were for disability or qualification for a reserve retirement at age 60.

RECOMMENDATION:

Congress should combine all active duty and reserve MGIB programs and tier benefits according to the service performed.

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Housing Grants

Increase in Amount of Grants and Automatic Annual Adjustments for Inflation:

Housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living.

VA provides specially adapted housing grants of up to $50,000 to veterans with service-connected disabilities consisting of certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries. Veterans with service-connected blindness alone or with loss or loss of use of both upper extremities may receive a home adaptation grant of up to $10,000.

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but among the most seriously disabled service-connected veterans. Congress should increase the grants this year and amend the law to provide for automatic adjustment annually.

RECOMMENDATION:

Congress should increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost of living.

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Grant for Adaptation of Second Home:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and changes in the special adaptations. These things merit a second grant to cover the costs of adaptations to a new home.

RECOMMENDATION:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

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Automobile Grants and Adaptive Equipment

Increase in Amount of Grant and Automatic Annual Adjustments for Increased Costs:

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

The Department of Veterans Affairs provides certain severely disabled veterans and service members grants for the purchase of automobiles or other conveyances. This grant also provides for adaptive equipment necessary for safe operation of these vehicles. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. With subsequent cost-of-living increases in the grant, Congress sought to provide 85 percent of the average cost of a new automobile, and later 80 percent. Until the 2001 increase to $9,000, the amount of the grant had not been adjusted since 1988, when it was set at $5,500.

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles, according the National Automobile Dealers Association, was $21,750. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is $28,105. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,484.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2006. And to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

RECOMMENDATION:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile and provide for automatic annual adjustments in the future.

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Home Loans

No Increase in, and Eventual Repeal of, Funding Fees:

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of VA home loans.

Congress initially imposed funding fees upon VA guaranteed home loans under budget reconciliation provisions as a temporary deficit reduction measure. Now, loan fees are a regular feature of all VA home loans except those exempted. During its first session, the 108th Congress increased these loan fees. The purpose of the increases was to generate additional revenues to cover the costs of improvements and cost-of-living adjustments in other veterans' programs. In effect, this legislation requires one group of veterans (and especially our young active duty military), those subject to loan fees, to pay for the benefits of another group of veterans, those benefiting from the programs improved or adjusted for increases in the cost of living.

First and foremost, it is the position of *The Independent Budget* that veterans' benefits, provided to veterans by a grateful nation in return for their contributions and sacrifices through service in the armed forces should be entirely free. In addition, *The Independent Budget* finds it entirely indefensible that Congress can only make improvements or adjustments in veterans' programs for inflation by shifting the costs onto the backs of other veterans. The government, not veterans, should bear the costs of veterans' benefits. With these increased funding fees, the advantages of VA home loans for veterans are being negated. These fees are increasing the burdens upon veterans purchasing homes while the intent of VA's home loan program is to lessen the burdens.

RECOMMENDATION:

Congress should refrain from further increasing home loan funding fees and should, as soon as feasible, repeal these fees entirely.

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INSURANCE

Government Life Insurance

Value of Policies Excluded from Consideration as Income or Assets:

For purposes of other government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance polices and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

RECOMMENDATION:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other federal programs.

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Lower Premium Schedule for Service-Disabled Veterans' Insurance:

The Department of Veterans Affairs (VA) should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. Congress therefore created the SDVI program to furnish disabled veterans life insurance at standard rates. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. VA continues to base its rates on mortality tables from 1941 however. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

RECOMMENDATION:

Congress should enact legislation to authorize VA to revise its premium schedule for SDVI to reflect current mortality tables.

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Increase in Maximum Service-Disabled Veterans' Insurance Coverage:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (SDVI) does not provide adequately for the needs of survivors.

When life insurance for veterans had its beginnings in the War Risk Insurance program, first made available to members of the armed forces in October 1917, coverage was limited to $10,000. At that time, the law authorized an annual salary of $5,000 for the Director of the Bureau of War Risk Insurance. Obviously, the average annual wages of service members in 1917 was considerably less than $5,000. A $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917.

Today, more than 88 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage well more than three-quarters of a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

A May 2001 report from an SDVI program evaluation conducted for the Department of Veterans Affairs recommended that basic SDVI coverage be increased to $50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to at least $50,000.

RECOMMENDATION:

Congress should enact legislation to increase the maximum protection under base SDVI policies to at least $50,000.

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Veterans' Mortgage Life Insurance

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

RECOMMENDATION:

Congress should increase the maximum coverage under VMLI from $90,000 to $150,000.

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OTHER SUGGESTED BENEFIT IMPROVEMENTS

National Guard and Reserve Benefits:

Congress must improve and modernize federal benefits for members of the National Guard and Reserve forces.

The decade-long trend of our increasing reliance on National Guard, Air National Guard, and the Reserve forces of the Army, Navy, Marine Corps, Air Force, and Coast Guard for national security missions at home and peacekeeping and combat missions overseas, bears no sign of abatement. Reliance on Guard and Reserve forces has grown since the pre–Persian Gulf War era, and this trend continues even though both Reserve and active duty force levels remain far below their Cold War peak.

Since September 11, 2001, more than 410,000 individuals who serve in National Guard and Reserve forces have been mobilized for a variety of military, police, and security actions. Increasing demands on these serving members impose significant and repeated family separations (the single greatest disincentive for a military career) and create additional uncertainty and interruptions in their civilian career opportunities.

Furthermore, Guard and Reserve recruiting, retention, morale, and readiness are already at considerable risk. The nation cannot afford to promote the perception that we undervalue the great sacrifices and level of commitment being demanded from the Guard and Reserve community.

Various incentive, service, and benefit programs designed a half century ago for a far different Guard and Reserve philosophy are no longer adequate to address demands on today's Guard and Reserve forces. Accordingly, steps must be taken by Congress to upgrade National Guard and Reserve benefits and support programs to a level commensurate with the sacrifices being made by these patriotic volunteers. Such enhancements should provide Guard and Reserve personnel a level of benefits comparable to their active duty counterparts and provide one means to ease the tremendous stresses now being imposed on Guard and Reserve members and their families, and to bring the relevance of these benefits into 21st century application.

RECOMMENDATION:

With concern about the current missions of the Guard and Reserve forces, Congress must take necessary action to upgrade and modernize Guard and Reserve benefits, to include more comprehensive health care, equivalent Montgomery GI bill educational benefits, and full eligibility for the VA Home Loan guaranty program.

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Protection of Veterans' Benefits Against Claims of Third Parties

Restoration of Exemption from Court-Ordered Awards to Former Spouses:

Through interpretation of the law to suit their own ends, the courts have nullified plain statutory provisions protecting veterans' benefits against claims of former spouses in divorce actions.

Congress has enacted laws to ensure veterans' benefits serve their intended purposes by prohibiting their diversion to third parties. To shield these benefits from the clutch of others who might try to obtain them by a wide variety of devices or legal processes, Congress fashioned broad and sweeping statutory language. Pursuant to 38 U.S.C. § 5301(a), "[p]ayments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equi-

table process whatever, either before or after receipt by the beneficiary."

Thus, while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the United States government. Veterans cannot voluntarily or involuntarily alienate their rights to veterans' benefits. The justification for this principle in public policy is one that can never obsolesce with the passage of time or changes in societal circumstances.

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless. Various courts have shown no hesitation to force disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

We should never lose sight of the fact that it is the veteran who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and the other social and lifestyle constraints that result from disability. The needs and well being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is a personal entitlement of the veteran, without whom there could never be any secondary entitlement to compensation by dependent family members. Therefore, federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

RECOMMENDATION:

Congress should amend 38 U.S.C. § 5301(a) to make its exemption of veterans' benefits from the claims of others applicable "notwithstanding any other provision of law" and to clarify that veterans' benefits shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever "for any purpose."

General Operating Expenses

From its central office in Washington, D.C., and through a nationwide system of field offices, the Department of Veterans Affairs (VA) administers its veterans' benefits programs. Responsibility for the various benefit programs is divided among five different services within the Veterans Benefits Administration (VBA): Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from VA's Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant secretaries provide departmental management and administrative support. These offices along with the Office of General Counsel and the Board of Veterans' Appeals are the major activities under the General Administration portion of the General Operating Expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system—VBA and its constituent line, staff, and support functions—and the functions under General Administration.

The best-designed benefit programs achieve their intended purposes only if the benefits are delivered to entitled beneficiaries in a timely manner and in the correct amounts. *The Independent Budget* veterans service organizations make the following recommendations to maintain VA's benefits delivery infrastructure and to improve VA performance and service to veterans.

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

VBA Management

More Authority Over Field Offices:

Department of Veterans Affairs (VA) program directors should have more accountability for benefits administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions.

The VBA's current management structure presents a serious obstacle to enforcement of accountability, however, because program directors lack direct authority over those who make claims decisions in the field. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines and have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to advise the Under Secretary to enforce quality standards and program policies within their respective benefit programs. While higher-level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have more accountability for the field decision-making process and should be enabled to advise the Under Secretary to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed many of the VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates the VBA. In turn, field personnel perceived VBA's central office staff as incapable of taking firm action. NAPA said that a number of executives interviewed by its study team indicated that the VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding the Compensation and Pension Service (C&P) especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability. We continue to agree with that assessment and urge the Under Secretary to empower the C&P director to become more involved in direct field operations.

In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment (VR&E) Task Force recommended that the director of the VR&E Service be given "some line-of-sight authority for the field administration of the program." We agree with this assessment as well.

RECOMMENDATION:

To improve the management structure of the VBA for purposes of enforcing program standards and raising quality, VA's Under Secretary for Benefits should give VBA program directors more accountability for the performance of VA regional office directors.

VBA Initiatives

Investment in VBA Initiatives:

To maintain and improve efficiency and services, the Veterans Benefits Administration (VBA) must continue to upgrade its technology and training.

To meet ever-increasing demands and maintain efficiency, any benefits system must continually modernize its tools. With the continually changing environment in claims processing and benefits administration, the VBA must continue to upgrade its information technology infrastructure and revise its training to stay abreast of program changes and modern business practices.

Despite these undeniable needs, Congress has steadily and drastically reduced funding for VBA initiatives over the past five fiscal years. In FY 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and, in 2006, $23 million. Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard to the added loss of buying power due to inflation.

With restored investments in initiatives, the VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. The VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery.

Some initiative priorities for funding follow:

- Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET) for the Compensation and Pensions Service, the Education Expert System (TEES) for the Education Service, and Corporate WINRS (CWINRS) for the Vocational Rehabilitation and Employment Service.

  VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

- Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing of claims data.

  Virtual VA supports pension maintenance activities at three pension maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. This initiative is to modify and enhance TIMS to make it fully interactive to allow for fully automated claims and award processing by Education Service and VR&E nationwide.

- Upgrading and enhancement of training systems.

  VA's Training and Performance Support Systems (TPSS) is a multimedia, multi-method training tool that applies Instructional Systems Development methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

  VBA initiated its "Skills Certification" instrument in 2004. This tool helps the VBA assess the knowledge base of veterans service representatives. The VBA intends to develop additional skills certification modules to test rating veterans service representatives, decision review officers, field examiners, pension maintenance center employees, and education veterans claims examiners.

- Accelerated implementation of Virtual Information Centers (VICs).

  By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA achieves greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced information technology, *The Independent Budget* veterans service organizations believe a conservative increase of at least 5 percent annually in VBA initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount for FY 2008 would be $115.4 million.

RECOMMENDATION:

Congress should provide $115.4 million for VBA initiatives to improve its information systems.

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Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To overcome the persistent and longstanding problem of large claims backlogs and consequent protracted delays in the delivery of crucial disability benefits to veterans and their families, the administration must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency within the Veterans Benefits Administration.

A core mission of the Department of Veterans Affairs is to provide financial disability compensation, dependency and indemnity compensation, and disability pension benefits to veterans and their dependent family members and survivors. These payments are intended by law to relieve economic effects of disability (and death) upon veterans and to compensate their families for loss. For those payments to effectively fulfill their intended purposes, VA must deliver them promptly, based on accurate adjudications. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits. Also, the need for financial support among disabled veterans is generally urgent. While awaiting action by VA on their pending claims, they and their families must suffer hardships; protracted delays can lead to deprivation and even bankruptcy. Some veterans have died while their claims for disability were unresolved for years at VA. In sum, VA disability benefits are critical, and meeting the needs of disabled veterans should always be a top priority of the federal government.

Recently VA has adopted a tactic of diverting public attention away from the structural claims backlog it holds by demonstrating great speed and efficiency in adjudicating the claims of wounded soldiers and Marines from the current conflicts in Iraq and Afghanistan. While boasting it is breaking all records in awarding these new veterans their rightful benefits, hundreds of thousands of claims of older veterans from prior conflicts and military services during earlier periods lie dormant, awaiting some future resolution. While we applaud VA's efforts to help new veterans, VA continues to fail older veterans every day that the backlog grows.

VA can promptly deliver benefits to veterans only if it can adjudicate and process their claims in a timely and accurate fashion. Given the critical financial importance of disability payments, VA has an undeniable responsibility to maintain an effective delivery system, and to take decisive and appropriate action to correct deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its growing claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity.

Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in disposition of claims, VA has lost ground on that problem, with

the backlog of pending claims growing substantially larger in recent years. In fact, looking retrospectively over the past six years, the backlog of compensation claims has moved from the December 2000 total of 363,412, to the September 2006 level of 589,583, a more than 50 percent increase during a period when three VA Secretaries of both political parties have stated publicly on multiple occasions that reducing this chronic backlog was their highest management priority. We also note that during this same period as these promises were being made, VBA staffing has essentially remained flat at about 9,000 FTEEs.

Historically, many underlying causes have acted in concert to bring on this seemingly intractable problem. These include poor management, misdirected goals, lack of focus or the wrong focus on cosmetic fixes, poor planning and execution, and outright denial of the existence of the problem—rather than the development and execution of real strategic remedial measures. These dynamics have been thoroughly detailed in several studies and reviews of the continuing problem, but they persist without remedy. While the problem has been exacerbated by lack of action, the IBVSOs believe most of the causes can be directly or indirectly traced to availability of resources. The problem was primarily triggered and is now perpetuated by insufficient resources.

Instead of requesting the additional funds and personnel needed to accomplish better results, the Administration has sought and Congress has provided fewer VBA resources. Recent budgets have requested actual reductions in full-time employees for the Veterans Benefits Administration—those who process the claims. Such reductions in staffing are clearly at odds with the realities of VA's growing workload and VA's own well-established adjudication policies and procedures. Adjudication of veterans' claims is a labor-intensive and "hands on" system of decision-making with lifelong consequences. These management and political decisions have conspired to diminish VA's quality of claims processing and to lose ground against the claims backlog. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task at hand. The priorities and goals of the immediate political stagnation are at odds with the need for a long-term strategy by VA to fulfill its mission and confirm the nation's moral obligation to disabled veterans.

VA must establish a long-term strategy focused principally on attaining quality and not merely achieving production quotas in claims processing, or emphasizing how well and efficient it deals with the needs of new veterans of current wars. It must obtain supplementary resources for VBA, and it must invest these in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can VBA proceed in a way that veterans' needs are addressed timely with the effects of disability alleviated by prompt delivery of appropriate benefits. Already-disabled veterans should not have to needlessly suffer additional economic deprivation because of the inefficiency and ultimately, the benign neglect, of their government. We believe this situation defines the very concept of "unconscionable."

As directed by law, VA has a duty to assist veterans in developing and presenting their claims. Congress established a special Federal Court to hear any disputes that arise as VA adjudicates those claims, and veterans possess the right by law to appeal their disagreements with adjudication decisions to a special appeals board as well. That self-checking system exists because national veterans organizations including the *IBVSOs* have insisted historically that veterans' war injuries and other service-related health problems be dealt with in a humane manner, and without rancor to the greatest extent practicable. The *IBVSOs* believe that each veteran who is awarded compensation is entitled to *full payment* and that no disabled veteran should be forced to obtain a private attorney to secure a proper and accurate disability rating from VA.

RECOMMENDATIONS:

To seek the beginning of the end of this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* recommends funding levels for fiscal year 2008 adequate to meet the real staffing and other needs of the Veterans Benefits Administration. We urge the Administration and Congress to enact a higher level of resources in VA's fiscal year 2008 appropriation.

VA should establish a new strategy, premised on obtaining sufficient staff and other resources, to reduce the claims backlog with accurate adjudications to an irreducible minimum backlog. As a part of this strategy, VA should implement a new communications plan that will better inform veterans and the organizations that represent them of the status and progress of their claims.

Sufficient Staffing Levels:

To overcome its claims backlog and meet an increasing workload, the Department of Veterans Affairs (VA) must be authorized to increase its staffing for the Compensation and Pension (C&P) Service.

Despite ongoing efforts to reduce the unacceptably large claims backlog, the C&P has been unable to gain ground on its pending claims. Experience has shown that this problem has persisted primarily because inadequate resources compounded by higher claims volumes.

During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.") With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, no reason exists to believe that growth rate will decline during FY 2006 and FY 2007. With a 9 percent increase over the FY 2005 number of claims, VA can expect 874,136 claims for C&P in FY 2007, although it should be acknowledged that actual receipts totaled 810,000 in FY 2006, while VBA had expected to see more than 900,000 during the period. Whatever levels of C&P claims are received in FY 2007 and 2008, it is true that the overall backlog is growing, not shrinking. Without adequate resources and better performance by claims processing staffs, no reason exists to believe VA will be able to hold its pending claims backlog to existing levels, much less ever reduce it.

Moreover, legislation requiring VA to invite veterans in six states to request review of past claims decisions and ratings in their cases and to conduct outreach to invite new claims from other veterans in these states will add substantially to the expected increased workload. It is projected that, of the approximately 325,000 veterans receiving disability compensation and the additional estimated 50,000 who will be invited to file new claims, 15 percent will seek new or increased benefits, resulting in an estimated 56,000 additional claims. Given past claims-processing times, much of this workload will carry over into FY 2008, making the new total more than 930,000 claims in FY 2008.

In its budget submission for FY 2007, VA projected production based an output of 109 claims per direct program full-time employee (FTE). *The Independent Budget* veterans service organizations (IBVSOs) have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, thus resulting in compromised quality, higher error and appeal rates, even greater system overload, and further adding to the claims backlog. We believe a more reasonable estimate of accurate productivity is 100 claims per FTE. In addition to recommending staffing levels more commensurate with its expected workload, we have maintained that VA should invest more in training adjudicators and that it should identify ways to hold them more directly accountable for higher standards of accuracy in the claims they process or oversee.

In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards when ensuring there is sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high-quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, the IBVSOs believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTE. With an estimated 930,000 claims in FY 2008, that would require 9,300 direct program FTEs. With the FY 2007 level of 1,375 support FTEs added (primarily for management support and information

technology), this would require C&P to be authorized 10,675 total FTEs for FY 2008. These totals do not accommodate the kinds of demands that may arise as a consequence of Congressional injection of attorneys into the claims process, which may eventuate even more increases in C&P staffing in future years, but it is reasonable to expect that involving attorneys will negatively impact per capita productivity in the claims adjudication process.

RECOMMENDATIONS:

Congress should authorize 10,675 total FTEs for the C&P Service for FY 2008.

Congress should authorize the VBA to contract for disability medical examinations using its mandatory funding account without limitation. Currently, the VBA operates under "pilot" legislative language that confines the use of the mandatory account to an original 10 VA regional office sites. Should the Under Secretary determine that the need exists to go beyond those sites in getting these examinations scheduled more timely using contract physicians, the VBA must use its discretionary dollars to do so. This new flexibility of funds use would enable the VBA to improve processing timeliness of claims—a goal of *The Independent Budget.*

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Vocational Rehabilitation and Employment

Adequate Staffing Levels:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Team, VR&E needs to increase its staffing.

Given its increased reliance on contract services, VR&E needs approximately 100 additional full-time employees (FTE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended in its March 2004 report creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To implement reforms to improve the effectiveness and efficiency of its programs, the task force recommended that VA should add approximately 200 new FTE positions to the VR&E workforce. The FY 2007 total of 1,125 FTEs for VR&E should be increased by 250, to 1,375 total FTEs.

RECOMMENDATION:

Congress should authorize 1,375 total FTEs for the VR&E Service for FY 2008.

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Education Service

Adequate Staffing:

To meet its increasing workload demands, the Education Service needs to increase direct program full-time employees (FTEs).

As it has with its other benefit programs, the Department of Veterans Affairs (VA) has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTEs were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2008. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTEs at the end of FY 2003 in relation to the workload at that time, the Veterans Benefits Administration must increase direct program staffing in its Education Service in FY 2008 to 873 FTEs, 149 more direct program FTEs than authorized for FY 2007. With the addition of the 160 support FTEs as currently authorized, the Education Service should be provided 1,033 total FTEs for FY 2008.

RECOMMENDATION:

Congress should authorize 1,033 total FTEs for the VA Education Service.

Judicial Review in Veterans' Benefits

In 1988, Congress recognized the need to change the situation that had existed throughout the modern history of veterans' programs in which claims decisions of the Department of Veterans Affairs (VA) were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from VA's Board of Veterans' Appeals (BVA).

Now, VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established the CAVC, it added another beneficial element to appellate review. It created oversight of VA decision making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

For the most part, judicial review of the claims decisions of VA has lived up to positive expectations of its proponents. To some extent it has also brought about some of the adverse consequences foreseen by its opponents. Based on past recommendations in *The Independent Budget*, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. In its initial decisions construing some of these changes, the CAVC has not given them the effect intended by Congress to ensure that veterans have meaningful judicial review in all aspects of their appeals. More precise adjustments are still needed to conform CAVC review to congressional intent.

In addition, most of VA's rulemaking is subject to judicial review, either in connection with a case before the CAVC or upon direct challenge to the United States Court of Appeals for the Federal Circuit. Here again, changes are needed to bring the positive effects of judicial review to all of VA's rulemaking.

Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

To achieve its intent that the Court of Appeals for Veterans Claims (CAVC) enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the court's scope of review.

The CAVC upholds Department of Veterans Affairs (VA) factual findings unless they are clearly erroneous. Clearly erroneous is the standard for appellate court reversal of a district court's findings. When there is a "plausible basis" for a factual finding, it is not clearly erroneous under the case law from other courts, which the CAVC has applied to Board of Veterans' Appeals (BVA) findings.

Under the statutory "benefit-of-the-doubt" standard, the BVA is required to find in the veteran's favor when the veteran's evidence is at least of equal weight as that against him or her, or stated differently, when there is not a preponderance of the evidence against the veteran. Yet, the court has been affirming any BVA finding of fact when the record contains the minimal evidence necessary to show a plausible basis for such finding. This renders the statutory benefit-of-the-doubt rule meaningless because veterans' claims can be denied and the denial upheld when supported by far less than a preponderance of evidence against the veteran.

To correct this situation, Congress amended the law to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. With this statutory requirement, the CAVC can no longer properly uphold a BVA finding of fact solely because it has a plausible basis inasmuch as that would clearly contradict the requirement that the CAVC's decision must take into account whether the factual finding adheres to the benefit-of-the-doubt rule. The court can no longer end its inquiry after merely searching for and finding a plausible basis for a factual determination. Congress intended for the CAVC to afford a meaningful review of both factual and legal determinations presented in an appeal before the court. Congress also amended the law to specify that the CAVC should, as a general rule, reverse erroneous factual findings rather than set them aside and allow the BVA to decide the question anew on remand.

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record, and the current record supports a conclusion opposite of that reached by the BVA. However, the CAVC has construed these amendments—intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule—as making no substantive change. The court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule as long as the court's scope of review retains the clearly erroneous standard. To ensure that the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

RECOMMENDATION:

Congress should amend 38 U.S.C. § 7261 of title 38 United States Code to provide that the court will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.

Court Facilities

Courthouse and Adjunct Offices:

The Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 16 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA General Counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The CAVC should have its own home, located in a dignified setting with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States.

Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

RECOMMENDATION:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the CAVC.

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COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to VA *Schedule for Rating Disabilities:*

The exemption of Department of Veterans Affairs (VA) changes to the rating schedule from judicial review leaves no remedy for arbitrary and capricious rating criteria.

Under 38 U.S.C. § 502, the Court of Appeals for the Federal Circuit (CAFC) may review directly challenges to VA's rulemaking. Section 502 exempts from judicial review actions relating to the adoption or revision of the VA *Schedule for Rating Disabilities*, however.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis reduction in earning capacity. The coauthors of *The Independent Budget* have become alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it so desired, VA could issue a rule that a totally paralyzed veteran, for example, would only be compensated as 10 percent disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the CAFC should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

RECOMMENDATION:

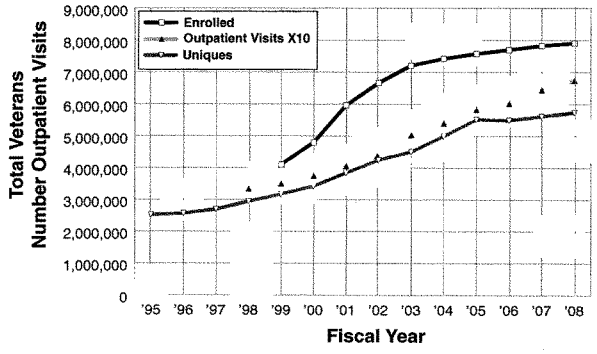
Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

Medical Care Introduction

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally the VHA is the nation's primary backup to the Department of Defense (DOD) in times of war or domestic emergency.

Of the 7.7 million veterans enrolled in fiscal year 2006, the VHA provided health care to more than 5.5 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.

CHART 1. UNIQUE VHA PATIENTS ENROLLED VETERANS AND TOTAL OUTPATIENT VISITS



This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care. The total number of estimated outpatient visits in fiscal year 2007 is expected to approach 65 million.

Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Year after year, the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past couple of years, *The Independent Budget* veterans service organizations are concerned that the methodology used in producing the statistics that indicate this reduction in the backlog may be skewed.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or safety net hospitals, often at higher per patient costs. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all veterans must be put in place.

Full implementation of VA electronic records into DOD health-care facilities

There has been a great deal of effort to develop proposals to promote VA/DOD initiatives within the medical care arena. Unfortunately, the results of those efforts have had minimal impact on agency operations. One very important link for the two agencies is the medical record. VA has developed an electronic record that has received major recognition throughout the medical community. It has allowed VA continue to meet the needs of its patients in an expeditious, efficient manner while reducing medical mistakes and duplication of testing while providing immediate availability of records at any of it locations nationwide. The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information.

Better coordination of the two electronic medical record systems will afford the opportunity to see tangible initiatives of VA/DOD programs. It will also expedite the handling of patient information especially in the transition of the patient from the DOD system to the VA system. It will provide a "complete" medical record that could be viewed by any appropriate provider within either system. It will also serve as a basic database for patients seeking compensation for service-related injuries. This database would be easily accessible and have a common language and arrangement of file information, making it easy for examiners to evaluate a patient's condition and needs.

MEDICAL CARE ISSUES

Financing Issues

Adequate Funding for VA Health Care Needed:

The Department of Veterans Affairs (VA) must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Last year (2006) proved to be a unique year for reasons very different from 2005. VA faced a tremendous budgetary shortfall during fiscal year (FY) 2005 that was subsequently addressed through supplemental appropriations and additional funds added to the FY 2006 appropriation. For FY 2007, the Administration submitted a budget request that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again.

For FY 2007, the Administration requested $31.5 billion for veterans' health care, a $2.8 billion increase over the FY 2006 appropriation. Although this was a significant step forward, Congress took a giant step backward by not following through on its responsibility to provide these funds. As of the start of the calendar year—and more than one-third of the way through the new fiscal year—VA still had not received its appropriation. It is unconscionable that Congress has allowed partisan politics and political wrangling to trump the needs of the men and women who have served and continue to serve in harm's way. When VA does not receive its funding in a timely manner, it is forced to ration health care. VA is unable to hire much-need medical staff to prepare for the needs of veterans who will be seeking health care. Waiting times will continue to increase and the quality of care will decrease as VA will actually be forced to cut staff. These factors continue to place enormous stress on the system and will leave VA struggling to provide the care that veterans have earned and deserve.

Last year the Administration finally recognized the work of *The Independent Budget* when it indicated that it would actually take $25.5 billion to fund Medical Services, an amount very close to what *The Independent Budget* veterans service organizations (IBVSOs) recommended. However, the IBVSOs certainly disagreed with the Administration's desire to use a new enrollment fee and an increase in prescription drug copayments to achieve that funding level. Once again the President's recommendation included the $250 enrollment fee for veterans in categories 7 and 8 and an increase in prescription drug copayments from $8 to $15 for a 30-day supply. VA estimated that these proposals would force nearly 200,000 veterans to leave the system and more than 1 million veterans to choose not to enroll. As in previous years, the Congress soundly rejected these proposals, and we urge Congress to continue to do again so if these fees are proposed this year.

Unfortunately, this delayed budget will also have a significant impact on the nursing shortage that VA is experiencing. When managers do not have a budget for the coming year, they are unable to plan for new hires of critical staff. VA is forced to place hiring freezes on its medical centers nationwide. The hiring freezes have forced individual medical facilities to assign non-nursing duties to current nurses. This detracts from immediate bedside care and ultimately jeopardizes the health of the veteran.

For FY 2008, *The Independent Budget* recommends $36.3 billion for VA health care. Unfortunately, Congress chose not to enact the VA appropriations bills during the 109th Congress, and it remains to be seen when the legislation will be completed. In order to form a baseline for funding for VA for FY 2008, we used the appropriations figures contained in H.R. 5385, the "Military Quality of Life and Veterans Affairs Appropriations Act for FY 2007." These amounts most closely represent the recommendations that we made in *The Independent Budget for FY 2007*.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2008, *The Independent Budget* recommends approximately $29.0 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

MEDICAL SERVICES RECOMMENDATIONS

(Dollars in Thousands)

Current Services Estimate	$26,302,464
Increase in Patient Workload	$ 1,446,636
Increase in Full-time Employees	$ 105,120
Policy Initiatives	$ 1,125,000
Total FY 2008 Medical Services	**$28,979,220**

Our increase in patient workload is based on a 5.5 percent increase in workload. The policy initiatives include $500 million for improvement of mental health services, $325 million for funding the fourth mission, and $300 million to support centralized prosthetics funding.

For Medical Administration, *The Independent Budget* recommends approximately $3.4 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $4.0 billion.

Although *The Independent Budget* health-care recommendation does not include additional money to provide for the health-care needs of category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA health-care system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million. The IBVSOs believe the system should be reopened to these veterans and that this money should be appropriated in addition to our Medical Care recommendation.

Furthermore, previous inadequate budgets have exacerbated the problem. In the past several years, the VA health-care budget has not even kept pace with the rising cost of inflation. VA has testified in the past that the Veterans Health Administration requires a minimum 13 percent to 14 percent increase just to meet this cost. VA cannot be competitive in the market for health-care professionals if it does not have the funding necessary to do so. For example, the IBVSOs believe that the basic salary for nurses who provide direct bedside care is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community.

In order to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process.

The Independent Budget's recommendations enable VA to meet the demands of current veterans and those who are now being denied care by VA. It ensures that VA is not faced with the possibility of a shortfall due to faulty modeling or any other reason. As the number of new veterans seeking health care continues to grow, and VA continues to care for veterans of prior conflicts, we must ensure that VA provides the quality health care that they have earned with their service and their sacrifices.

RECOMMENDATION:

Congress and the Administration must provide adequate funding for veterans' health care in a timely manner to ensure that VA can continue to provide the necessary services to all veterans seeking care.

Accountability:

Department of Veterans Affairs (VA) Veterans Health Administration (VHA) managers must be held individually responsible for their areas of operation to achieve needed enhancements to operations efficiency and effectiveness.

The Independent Budget veterans service organizations (IBVSOs) firmly believe that sufficient funding in and of itself is not enough to achieve greater efficiency of processes and people within VA and increased effectiveness of results in order to further its mission. Enforcing accountability within VA will directly contribute toward providing greatly enhanced benefits and services to veterans within the context of finite budgetary resources.

To make management structure and function more effective, VHA employees—at all levels—must be held individually responsible for their areas of operation. *The Independent Budget* insists upon much greater focus and, ultimately, meaningful improvement through enforceable accountability in such areas as waiting times for medical appointments; supervision of part-time physicians; contract care coordination, particularly specialty care from academic affiliates; fee-basis care; formulation of valid and reliable workload data and program reporting; timeliness of claims processing; and quality in claims adjudication.

■ Waiting Times for Medical Appointments

VA embarked on a nationwide initiative (the Advanced Clinic Access initiative) to provide frontline personnel the ability to maximize resources to treat more patients in a timely manner. As part of this initiative, the electronic wait list is utilized as a measuring tool for success. VA reports substantial reductions in the number of veterans on wait lists, and the VHA has also reduced the number of new enrollees waiting for their first clinic appointment. However, the accuracy of reported veterans' waiting times and facility wait lists is undermined by variability in VA's compliance with outpatient scheduling procedures and the cumbersome scheduling software being utilized from which waitlist data are being obtained.

While the current electronic waiting list has undergone a number of revisions since inception, reporting accuracy continues to be suspect and undermines the ability to produce effective and meaningful policy and procedures to best capture what is considered a symptom of an inadequately funded health-care system.

■ Contract Care, Particularly Specialty Care Provided by Academic Affiliates

Many VA facilities award contracts with academic affiliates to provide needed medical care to sick and disabled veterans. However, some contracts contain no procedures for VA to monitor contract physician presence and level of performance to ensure that the level of services VA pays for under the contract is actually provided.

Flaws in the procurement process must be addressed and appropriately corrected; otherwise, these factors affect the contract's "price reasonableness determination" (whether the contract itself is in the best interest of the government). For example, solicitation during the procurement process does not adequately compensate VA for any losses incurred as a result of noncompliance nor require penalties for noncompliance with the terms and conditions of the contract. Furthermore, there are instances where VA physicians receiving compensation from the affiliate or its practice group are involved in the contracting process in violation of federal ethics laws and regulations.

■ Fee-Basis Care

To ensure access to and a full continuum of health-care services, VA should better coordinate clinical and claims information for veterans authorized to receive medical care from private community-based providers at VA expense. While required to receive minimal treatment records from a veteran's private physician as part of authorization to receive non-VA care, there is no requirement to ensure that VA receives the complete medical record of the veteran to be made part of his or her electronic VA health record. In addition to maintaining the quality or care veterans receive through this program, requiring the receipt of all medical records for the episode of care also would decrease the likelihood that the claim for services rendered will not be paid or delayed as a result of VA determination that the claim is incomplete to adjudicate for payment.

■ Timeliness of Claims Processing and Quality in Claims Adjudication

There has been an ongoing challenge to reduce the backlog of claims being processed by VA. In many cases it can take years to get proper adjudication of a claim. Of greater concern is the number of errors in processing claims and the number of times claims must be remanded. The Veterans Benefits Administration's current focus on reducing the quantity of claims without an equal or greater focus on increasing the quality of decisions potentially increases the backlog. The focus on quantity of claims completed rather than a properly adjudicated claim is an easy way out of the backlog dilemma. It is easy to track and allows VA to claim success. But the focus should be on proper completion of an initial claim.

Issues that contribute to the focus on claims processing are awards and evaluations that are based on claims completed or on the reduction of backlog. This invariably forces the focus to production and not quality. A focus on quantity may also reduce quality because of the lack of accountability for incorrect claims. Without a doubt, most claims adjudicators are conscientious VA employees that desire to do the best job they can. But because claims are no longer remanded to the regional office that is processing the claim, there is no overt indication of a reduction in quality by the claims office. Only in the most remote of circumstances will responsibility for an improperly completed claim come back to reflect on the rating veterans service representative or Dispute Resolution Office adjudicator.

It is critical that a more objective method be developed for claims oversight and adjudicator evaluation. By setting specific performance standards that emphasize accuracy and quality, in addition to quantity, a more successful process may be created. Speed in claims processing cannot be ignored, and a requirement for the number of claims processed is helpful in evaluating employee work. But this is only beneficial when considered in conjunction with accurate work.

In order to have meaningful accountability, so as to provide greatly enhanced benefits and services to veterans, it is essential that management be provided all the requisite guidance and tools to enforce performance standards among the personnel under their direction. Management must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance. Correspondingly, performance appraisals and senior executive contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately sanctioned to enforce accountability and to promote a more efficient and effective provision of benefits and services to veterans. Furthermore, there must be greater transparency and oversight of network and facility performance plans to adjust the aspect of responsibility and accountability toward those that this federal agency was created to serve: sick and disabled veterans.

VA faces many challenges in its effort to use its limited resources efficiently, ensure reasonable access to high-quality health care, and manage its disability programs effectively. VA executives must be effective leaders, not just competent managers, particularly when making difficult decisions and taking decisive actions in a resource constrained environment.

RECOMMENDATIONS:

VA management must be provided with the requisite tools to enforce performance standards among the personnel under their direction.

VA must enforce meaningful performance standards. VA should then reward those individuals who exceed the standards and properly sanction those whose performance is substandard or unacceptable.

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Assured Funding:

The Administration's discretionary budget formulation for Department of Veterans Affairs (VA) health care and the manner in which Congress addresses these needs in the budget and appropriations acts are deeply flawed and cry out for true reform.

Budget formulation for veterans' health care continues to confound Congress and the Administration. While leaders in both government branches continue to boast about the "record-setting" increases they have produced compared to their predecessors, VA sources and sick and disabled veterans seeking VA health care tell a different story of crisis in the daily operating environment of the VA health-care system.

In both fiscal years 2005 and 2006, Congress was forced to confront VA health-care funding shortages with emergency or supplemental appropriations totaling nearly $3 billion. In 2006, VA continued to face challenges to meet known and expected demands for health care. Now, several months into fiscal year 2007, VA remains under the burden of a Continuing Resolution (CR) that maintains funding at the FY 2006 level. Likewise, we continue to hear reports that VA facilities must restrict services provided to veterans, delay hiring of new clinical staff, institute local and regional freelance policies to restrict eligibility and care, and impose a variety of questionable—and potentially hazardous—cost-cutting measures just to make ends meet. With the acknowledged budget shortfalls for veterans' health care in FY 2005 and FY 2006, and another CR for the first several months of FY 2007, the record is clear that VA operates in a state of management paralysis, planning chaos, and structural financial crisis as a direct consequence of the discretionary budget process.

Although welcomed, temporary funding supplements provided by Congress in urgent circumstances do not solve the underlying problem. For this reason, *The Independent Budget* veterans service organizations (IBVSOs) propose a lasting solution in the form of mandatory, assured, or guaranteed funding, or a workable combination of mandatory and discretionary funding, for veterans' health care. An assured system, even one that provided only partial guarantees, would make the management of veterans' health care more dependable and stable and eliminate the uncertainties that have perennially disrupted management of VA health care. Funding uncertainty has prevented VA executives and managers from being able to adequately plan for and meet the needs of a growing enrolled-veteran population, of which a large majority either service-disabled or poor. A guaranteed system of funding also would resolve the serious challenges created by late-arriving supplemental funds and stop the meddling on policy and politically motivated budget gimmicks proposed by the Office of Management and Budget.

Reforming VA's health-care budget is more important today than ever. The current conflicts in which our nation is engaged are producing a significant number of veterans suffering from traumatic amputations, brain injuries, blindness, burns, spinal cord injuries, and post-traumatic stress disorder (PTSD). These severely disabled veterans will need a lifetime of specialized health care. Veterans injured in Iraq, Afghanistan, and other parts of the world, as well as veterans wounded in previous conflicts, need the government's assurance that VA will remain a stable and reliable provider that receives sufficient funding to provide the specialized services they will need and have earned through their military service.

The Administration must also consider other costs the Veterans Health Administration (VHA) has incurred as it struggles to fulfill its core mission and mandates. Even with the stress of a chronic budget shortfall, VA was an integral part of the national and regional response providing emergency relief to veterans and all residents affected by the 2005 storms in Louisiana, Mississippi, Alabama, Texas, and Florida. During these disasters, VA played an indispensable role, not only in continuing to serve sick and disabled veterans but also serving the Gulf Coast community in general with rescue, security and police, health-care, transport, and other lifesaving services. Although necessary and admirable, VA is not funded to carry out this type of mission without compromising or disrupting its ability to care for veterans in routine operations. The IBVSOs continue to strongly recommend that VA be provided funds to replenish its expenditures for such additional services in times of emergency.

The IBVSOs also remain concerned that under a discretionary budgeting method the VHA remains vulnerable to the political pressures of cost-cutting proposals, such as those suggested in 2006. If higher copayments or other cost-saving measures are imposed,

some veterans undoubtedly will be forced out of the VA system only to fall back on Medicaid, Medicare, and other government-sponsored programs. VA's existence reduces the financial burden on other federal and state health-care systems. If funded adequately, the VA health-care system, by many measures, offers the most cost-effective and highest quality health-care services available in the United States to care for America's sick and disabled veterans.

During the 109th Congress, assured funding bills were introduced in both chambers. Unfortunately, none of these measures were enacted. The Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations, has urged the Administration and Congress to reform the method for funding veterans' health care. Our repeated requests for hearings and public debate on this key issue were denied or ignored by the House and Senate authorizing and appropriations committees. Additionally, during the 109th Congress an alternative funding plan (combining mandatory with discretionary funding) was proposed to resolve VA's health-care funding crisis. Unfortunately, this proposal was also defeated—even with full support of the Partnership. In spite of an obvious need to reform the way VA health care is funded, the Administration and Congress embraced other prerogatives, such as tax cut extensions and massive pork barrel spending, that took precedence over ensuring health-care funding for millions of older veterans dependent on VA care and tens of thousands of men and women returning sick and disabled as a result of current military service for our country.

Providing health care to our nation's sick and disabled veterans is a continuing cost of defense and national security and should be a top priority of our government. We are hopeful that the 110th Congress will be open to addressing the issue of assured funding by holding hearings and making the necessary changes to reform the budget process for veterans' health care.

Without reform, all the current advantages of VA health care, originating from a decade of internal improvements, are at risk. The manner in which the Administration and Congress provide funding for VA health care poses well-documented annual uncertainty that prevents VA managers from planning effectively to continue these vital services. When funding is eventually secured, it has proven time and again to be insufficient, causing VA practitioners to ration and delay care needed by sick and disabled veterans who depend on VA, and even forcing a former VA Secretary to restrict access to new priority group 8 enrollments. Including VA's projection estimates for FY 2007, nearly one million veterans will have been denied access to VA health care as a result of that decision. Currently, combat veterans of the global war on terrorism have eligibility for two years of free VA health care for conditions potentially related to their military service after discharge or release—and according to VA will have continued access to such care after that time period regardless of the priority group to which they are assigned. However, we are concerned that if these veterans need to access the system after this two-year period, but have not used the system within the specially prescribed eligibility period and fall into priority group 8, they, too, would be ineligible for VA health-care services.

Our government needs to take the politics, guesswork, and political gamesmanship out of VA health care and fully fund this transparent need with an assured mechanism. The Administration has a fundamental obligation to provide Congress an honest, accurate statement of the VA's known financial needs. And Congress is obligated to fully fund VA health care in a timely manner. The best way to meet these obligations is to overhaul the budget and appropriations process to guarantee an adequate, predictable, reliable, and available funding stream to meet the health-care needs of America's sick and disabled veterans.

RECOMMENDATIONS:

The Administration and Congress must address the acknowledged shortfalls of the current approach and support legislation to reform funding for VA health care. This reform should move VA from its current status in domestic discretionary appropriations to full mandatory funding—or some combination of discretionary and assured funding—in order to ensure all eligible and enrolled veterans may gain and retain access to VA health care programs and services in a timely manner.

When funding has been ensured, VA should reopen enrollments to so-called "priority 8" veterans, or, at minimum, extend the two-year period of eligibility for free VA health care offered to combat veterans of the global war on terrorism for conditions potentially related to their military service after discharge or release.

Homeland Security/Funding for the Fourth Mission:

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

The Department of Veterans Affairs (VA) has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. The VA's fourth mission, as stated in a General Accounting Office Report of October 2001, is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

In 2005, the devastation created by Hurricanes Katrina and Rita in the Gulf Coast region more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans affected by the hurricanes. Nearly 10,000 VA employees around the country received recognition for their actions during the hurricanes, including 73 Valor Awards for risking personal safety to prevent the loss of human life or government property, and 3,000 official commendations. After Katrina, VA facilities along the Texas Gulf Coast prepared for Rita by stocking up on food, water, medical supplies, emergency communications (satellite telephones), and extra fuel for emergency generators and vehicles. VA facilities outside the Gulf Coast region were on standby to evacuate patients, and health-care professionals were ready to travel to the storm area if called upon. Yet the skills and abilities of VA were not leveraged to support other federal, state, and local agencies that struggled to react to these events. Had this occurred, it might have reduced the suffering of the region.

VA has statutory authority, under 38 U.S.C. § 8111A, to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed into law an "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002") has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security, VA, the DOD, and the Department of Health and Human Services. According to the VA website (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each VISN to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to those individuals affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002." This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or

responding to a disaster or emergency. These centers, although authorized by law, have not received any funding.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. The actions of VA in Louisiana, Mississippi, and Alabama in 2005 prove that VA has done everything it can to prepare itself under the requirements of the fourth mission. It has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the Medical Care Account, providing VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already-scarce resources will continue to be diverted from direct health-care services.

The VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services. The IBVSOs do not believe that VA currently has the resources it will need to adequately care for veterans. If VA is to fulfill its responsibilities, it must be provided these resources.

RECOMMENDATIONS:

Congress should provide funds necessary in the VHA's FY 2008 appropriation to fund VA's fourth mission.

Funding for the fourth mission should be included in a separate line item in the Medical Care Account.

Congress and the Administration should provide the funds necessary to establish and operate the four emergency preparedness centers created by P.L. 107-287.

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Seamless Transition from the Department of Defense to Veterans Affairs:

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As military service personnel return from the conflicts in Iraq and Afghanistan, the DOD and VA must provide them with a seamless transition of benefits and services when they leave military service and become veterans. Currently, the transition from the DOD to VA is anything but seamless, and undue hardship is placed on many new veterans trying to gain access to VA. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The Independent Budget supported the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report, released in May 2003, regarding transition of soldiers to veteran status. The PTF stated that "providing these individuals [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and the DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed." This need has not been fully met.

The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. We applaud the DOD for beginning to collect medical and environmental exposure data electronically while personnel are still in theater, and are confident this practice will continue. But it is equally important that this information be provided to VA. These electronic medical records should also include an easily transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Joint Electronic Health Records Interoperability plan, as agreed to by both VA and the DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchange of related health data between the two departments culminating in the bidirectional exchange of interoperable health information. However, with continued successes from the first phase through milestones in the second phase, achieving real-time sharing of computable health information is heavily dependent upon agreement on common health data standards and the development of technology not wholly under the control of either department. Moreover, the IBVSOs are not encouraged by reports that in some instances medical data gathered in theater and stored on electronic smart cards provided to the soldier are not even readable by other military medical facilities upon the service member's return. This does not bode well for an electronic system meant to exchange information between federal agencies.

The Independent Budget is not the only party concerned about this exchange. In June 2004, the Chairman and Ranking Member of both the House Committee on Veterans' Affairs and Committee on Armed Services sent letters to then-VA Secretary Principi and then-DOD Secretary Rumsfeld expressing concern with the current transition of servicemen and -women and indicating that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurs with the PTF's recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." The problem with separation physicals identified for active duty members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing reservists have improved in recent years, there are still a number of soldiers who "opt out" of the physical exams, even when encouraged by medical personnel to have them. Though the expense, manpower, and delays needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War syndrome, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

The IBVSOs also support the Army Wounded Warrior Program (AW2), formerly called the Disabled Soldier Support System, implemented in spring 2005, as well as the Marine for Life program. Their responsibility is to assist the most severely injured service members and their families in transition from military to civilian life. However, the AW2 program maintains only minimal staff with a limited budget. With a high number of severely injured service members returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance these successful programs.

While more progress needs to occur on health-care transition, in the past several years the DOD and VA have made some good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL's) Transition Assistance Program (TAP) handled by the Veterans Employment and Training Service (VETS) and VA Vocational Rehabilitation and Employment Disabled Transition Assistance Program (DTAP) are generally the first services that a separating service member will receive. In fact, local military commanders, through the insistence of the DOD, began to allow their soldiers,

sailors, airmen, and marines to attend well in advance so as to take greatest advantage of the program. Under this scenario, the programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their individual circumstances and then seek answers prior to discharge.

TAP and DTAP continue to improve. But challenges continue at some local military installations, at overseas locations, and with services and information for those with significant injuries. Disabled service members who wish to file a claim for VA compensation benefits and, thus, other ancillary benefits, are dissuaded by the possibility of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in conducting these programs, and the haphazard nature may allow some individuals to fall through the cracks. This is of particular risk in DTAP for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still remaining on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. Consequently, DTAP has not had the same level of success as TAP, and to improve this, it is critical that coordination be closer between the DOD, VA, and VETS.

The DOD, the DOL, and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. Despite the successes of TAP, the program lacks the flexibility required to meet the erratic surges in demand from soldiers who are rapidly discharged and demobilized en masse just a few months after returning from the front lines. Such short timelines force service members to enter veteran status without the benefits of TAP. Unless these soldiers are injured, they may clear the demobilization station in a few days or be discharged from active duty in a few weeks. DOD personnel at these sites are most focused on processing service members through the site, and little time is dedicated to informing them about veterans' programs. Lack of space and facilities often allows for limited contact with the demobilizing service members by VA representatives. Moreover, waiting lists for the TAP program have surfaced at some sites, primarily a result of the reduction in the number of TAP providers and the resulting limited class capacity in combination with large numbers of rapidly transitioning service members.

To address these issues, the number of TAP providers should be increased and the DOD should formally incorporate TAP at every demobilization station to ensure all new veterans are exposed to necessary information on VA benefits and services. In addition, those veterans who are unable to avail themselves of TAP while on active duty should be allowed to participate. For this purpose, the restriction that only active duty service members may participate in TAP should be eliminated. We recommend however that some prerequisites are met, including that veterans who are requesting to attend a TAP class not displace a service member. Furthermore, it is crucial that demand for such services be captured where each station providing TAP must report the number of recently discharged veterans requesting participation and, of those, the number of veterans who eventually completed TAP.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, a truly seamless transition must be created. In doing so, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and -women exiting military service should be afforded easy access to the health care and other benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve coordination and information sharing to provide a seamless transition.

RECOMMENDATIONS:

The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allow-

ing for two-way electronic exchange of computable health information and occupational and environmental exposure data. The records should also include an electronic DD214.

The DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process.

Congress and the Administration must provide additional funding for the AW2 and Marine for Life programs to allow for appropriate expansion of these programs to address the needs of more seriously disabled soldiers.

Mental Health Services:

Mental health services for older veterans must be maintained in addition to Department of Veterans Affairs (VA) efforts to address increased mental health challenges arising from the ongoing conflicts in Iraq and Afghanistan.

■ President's New Freedom Commission on Mental Health/VA Mental Health Strategic Plan

Following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health programs. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms, rather than aiding patients' recovery and restoration. The New Freedom Commission found that many people with mental illness can regain productive lives, and the effort provided the President and the government a bold new blueprint for system change based on the goal of recovery. VA leaders embraced the change the commission envisioned for the mental health system and developed an agenda for realizing that goal. VA established a National Mental Health Strategic Plan (MHSP) as an outgrowth of the President's New Freedom Commission report and promised to commit $100 million in fiscal year 2005 and $200 million in fiscal year 2006 to fund new mental health initiatives.

In November 2006, the United States Government Accountability Office (GAO) issued a report on resources allocated for VA's MHSP initiatives. The GAO found that VA did not allocate all of the funding it planned to commit in fiscal year 2005 for new mental health initiatives to address identified gaps in mental health services. Funding was intended to be used for such priorities as the expansion of post-traumatic stress disorder (PTSD) services, post-deployment mental health services for veterans returning from combat in Iraq and Afghanistan, and expansion of programs for the treatment of substance-use disorders. Additionally, the GAO reported that the VA Central Office did not inform network and medical center officials that certain funds were to be used for these specific mental health initiatives, and therefore it is likely some funds went for other health-care priorities. Likewise, according to the GAO, some medical center officials were not certain they would be able to spend all the funds planned for fiscal year 2006 for plan initiatives by the end of the year. These findings illustrate the need for continued Congressional oversight to ensure proper use of dedicated mental health funds for MHSP initiatives.

Additionally, *The Independent Budget* veterans service organizations (IBVSOs) understand that VA's internal policy on funding certain new initiatives to address gaps in services related to psychosocial rehabilitation and recovery-oriented services will be limited to only two years. The expectation is that this "seed money" provided to specific initiatives will generate sufficient creditable patient care workload counts through VA's internal resource allocation system to make further earmarks unnecessary after the first two years. This is an untested concept that may dampen local interest in proposing or embracing these new initiatives. If a VA medical center director believes that a centrally controlled earmark is temporary, there may be tempta-

tion to limit investment in the program. The aftereffects of this two-year funding policy warrant close scrutiny from mental health advocates and Congress.

■ Overseas Engagement

The U.S. military engagement in Southwest Asia extends into its fifth year. This is a difficult, dangerous campaign for American troops, whether they are regular active duty members, Reserves, or National Guard. Ground combat units have faced fierce fighting, whether in close combat in the streets and buildings of urban area or while traversing rugged mountain passes. Danger is imminent, even for military members working in support positions. The ever-present improvised explosive device (IED) threatens U.S. convoys as they travel treacherous roadways. Vehicular accidents are commonplace, and no one is immune. Despite the threats and risks, our regular active duty, National Guard, and Reserve forces are performing magnificently in current conflicts. Many Guard and Reserve members have served multiple tours of duty, leaving families and full-time civilian jobs when they were called to duty as citizen soldiers. Their families are also making extreme sacrifices.

■ Issues Affecting our Newest Generation of Combat Veterans

VA and the Department of Defense (DOD) are well aware that combat veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are at higher risk for PTSD and other mental health problems. In a 2006 study published in the *Journal of the American Medical Association*, Col. Charles Hoge, MD, of the Walter Reed Military Research Institute, evaluated relationships between combat deployment and mental health-care use in the first year following return from the war. The study also reviewed lessons learned from postdeployment mental health screening efforts, correlation between screening results and subsequent use of military mental health services, and attrition from military service.

The Hoge study found that 19 percent of soldiers and marines who had returned from Iraq screened positive for mental health problems, including PTSD, generalized anxiety, and depression. Hoge reported that mental health problems recorded on the postdeployment self-assessments by military service members were significantly associated with combat experiences and mental health-care referral and utilization. Thirty-five percent of Iraq war veterans had received mental health services in the year after returning home, and 12 percent each year were diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months postdeployment among soldiers preparing to return to Iraq for a second deployment. Hoge postulated that although OIF veterans are using mental health services at a high rate, many military personnel with mental health concerns do not seek help due to fear of stigma and other barriers. The study revealed that service members resisted care because of personal concerns over being perceived as weak—or that seeking treatment would have a negative impact on their military career. Finally, Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

The VA health-care system is also seeing increasing trends of health-care utilization among OEF/OIF veterans. VA reports that veterans of these current wars seek care for a wide range of possible medical and psychological conditions, including mental health conditions, such as adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. As of November 2006, VA reported that of the 205,000 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 73,157 unique patients had received a diagnosis of a possible mental health disorder. Nearly 34,000 of the enrolled OEF/OIF veterans had a probable diagnosis of PTSD.

VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health-care utilization among this group reflect the fact that these veterans have ready access to VA health care, which is free of charge for two years following separation from service for problems related to their wartime service. However, VA estimates that only 109,191 veterans of the Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than expected to see in 2006). With increased outreach, internal mental health screening efforts under way, and expanded access to health care for OEF/OIF veterans, we are concerned that these estimates are artificially low and could result in a shortfall in funding necessary to meet the demand. Experts agree that if newly returning

veterans do not have timely access to PTSD counseling and other readjustment services, an opportunity will be lost to reduce the severity of symptoms and more serious long-term chronic mental health problems in this population.

■ VA's Specialized PTSD Programs

According to VA, it operates a network of more than 190 specialized PTSD outpatient treatment programs throughout the country, including specialized PTSD clinical teams or a PTSD specialist at each VA medical center. Vet centers, which provide readjustment counseling in 207 community-based centers, have reported rapidly increasing enrollment in their programs, with nearly 77,000 readjustment counseling visits of OEF/OIF veterans in fiscal year 2005 and projected visits of 242,000 in fiscal year 2006.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health-care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The center offers a monthly five-day clinical training program to VA clinical staff and maintains a website (www.ncptsd.va.gov) with information about trauma and PTSD. The center also offers guidance on the effects of PTSD on family and work and notes treatment modalities and common therapies used to treat the disorder. Last year the center provided a guide for military personnel titled "Returning from the War Zone." This guide discusses common experiences in combat, postdeployment readjustment issues including the primary symptoms of PTSD, as well as other common stress reactions, such as depression, anger, aggressive behavior, alcohol and drug abuse, shame, guilt, and suicidal ideation. The center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. Included in the guide is a checklist of trauma symptoms for self-assessment, eligibility requirements for VA services, and guidance for seeking further help.

Because of increased roles of women in the military and their exposure to combat in OEF/OIF theaters, we encourage VA to continue to address, through its treatment programs and research initiatives, the unique needs of women veterans related to treatment of PTSD and military sexual trauma.

Although VA has improved access to mental health services at its 800-plus community-based outpatient clinics, such services are still not readily available at all sites. Likewise, VA has not yet achieved its goal of integration of mental health staff in all its primary care clinics. Also, we remain concerned about the capacity in specialized PTSD programs and the decline in availability of VA substance-use disorder programs of all kinds, over time, including virtual elimination of inpatient detoxification and residential treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and consequent rationed access to, these specialized services.

■ Traumatic Brain Injury and Mental Health

It has been said that traumatic brain injury (TBI)—caused by IEDs, vehicular accidents, gunshot or shell fragment wounds, falls, and other traumatic injuries to the brain and upper spinal cord—is the signature injury of Operations Enduring and Iraqi Freedom. Severe TBI resulting from blast injuries or powerful bomb detonations that severely shake or compress the brain within the skull often causes devastating and permanent damage to brain tissue. Likewise, veterans who are in the vicinity of an IED blast or involved in a motor vehicle accident can suffer from a milder form of TBI that is not always immediately detected and can produce symptoms that mimic PTSD or other mental health disorders. It is believed that many OEF/OIF veterans have suffered mild brain injuries/concussions that have gone undiagnosed and that symptoms will only be detected later, when these veterans return home. We are concerned about emerging literature (August 11, 2006, memorandum, issued by the Armed Forces Epidemiological Board regarding Traumatic Brain Injury in Military Service Members) that strongly suggests that even "mild" TBI patients may have long-term mental and medical health consequences. The DOD admits that it lacks a systemwide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI/concussion, in particular mild TBI/concussion. Therefore, VA should coordinate with the DOD to better address mild TBI/concussion injuries and develop a standardized follow-up protocol utilizing appropriate clinical assessment techniques to recognize neurological and behavioral consequences of TBI as recommended by

the Armed Forces Epidemiological Board. The influx of OEF/OIF service members returning with brain trauma has provided an increased opportunity for research into the evaluation and treatment of these injuries in newer veterans; however, we suggest that any studies include older veterans of past conflicts who may have also suffered similar injuries that went undetected, undiagnosed, and untreated.

The most severely injured service members will require extensive rehabilitation and lifelong personal and clinical support, including home caregiver, neurological and psychiatric services, physical, psychosocial, occupational, and vocational therapies. Currently VA has four designated TBI facilities: in Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; and Tampa, Florida. These TBI lead centers provide a full spectrum of TBI care for patients suffering moderate to severe brain injuries. VA is also establishing polytrauma centers in each of its Veterans Integrated Service Networks for follow-up care of polytrauma and TBI patients referred from the four lead centers or from military treatment facilities. In an attempt to raise awareness of TBI issues, VA requires training of primary care, mental health, spinal cord, and rehabilitation providers via a web-based independent study course. However, VA is still working to develop a systemwide screening tool for clinicians to use to assess TBI patients.

The VA's Office of the Inspector General (OIG) issued a revealing report in July 2006, "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed health care and other services provided for VA patients with TBI and then examined their status approximately one year following discharge from inpatient rehabilitation. The OIG found that improvement and better coordination of care were needed so veterans could make a smoother transition between the DOD and VA health-care services. The report also called for additional assistance to immediate family members of brain-injured veterans, including additional caregivers and improved case management.

VA has designated TBI as one of its special emphasis programs and is committed to working with the DOD to provide comprehensive acute and long-term rehabilitative care for veterans with brain injuries. We are encouraged that VA has responded to the growing demand for specialized TBI care and, fulfilling the requirements of Public Law 108-422, established four polytrauma rehabilitation centers (PRCs) that are colocated with the existing TBI lead centers. However, we remain concerned about capacity and whether VA has fully addressed the resources and staff necessary to provide intensive rehabilitation services, treat the long-term emotional and behavioral problems that are often associated with TBI, and to support families and caregivers of these seriously brain injured veterans. During a September 2006 House Veterans' Affairs Subcommittee on Health hearing, a statement was provided for the record that indicated the 20-year health-care costs for TBI could exceed $14 billion. As noted in the OIG report, "these problems exact a huge toll on patients, family members, and health care providers." There are several challenges we face in ensuring these veterans and their families get the specialized care and support services they need. Clinicians indicate that in the case of mild TBI, the [veteran's] denial of problems that can accompany damage to certain areas of the brain often leads to difficulties receiving services. Likewise, with more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

To help facilitate access to services, VA assigns a case manager to each OEF/OIF veteran seeking treatment at one of its medical facilities. The case manager is responsible for coordination of all VA services and benefits. Additionally, VA has created liaison and social work positions at DOD facilities to assist injured service members. In interviewing these case managers, the OIG found several problems that warrant attention. These case managers reported continued problems related to transfer of medical records from referring military facilities; difficulty in securing long-term placements of TBI patients with extreme behavioral problems; difficulty in obtaining appropriate services for veterans living in geographically remote areas; limited ability to follow patients after discharge to remote areas; poor access to transportation and other resources; and inconsistency in long-term case management. The report found that while many of the patients they assessed had achieved a substantial degree of recovery, *"...approximately half remained considerably impaired."* The report concluded that improved coordination of care is necessary between agencies, and that families need additional support in the care of TBI patients.

Finally, the IBVSOs are concerned about media accounts and reports from veteran patients with TBI and their family members who claim that VA care for TBI is not up to par—requiring them to seek rehabilitation services in the private sector. We encourage VA and Congress to address these types of complaints to ensure severely wounded TBI veterans are receiving the best rehabilitative care available.

■ SUMMARY

Overall, we are pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that the DOD has acknowledged that it needs to conduct more rigorous pre- and postdeployment health assessments and reassessments with military service personnel who serve in combat theaters and that it is working to improve collaboration with VA to ensure this information is accessible to VA clinicians. Likewise, VA and the DOD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from achieving the universal goal of "seamless transition."

Emerging evidence suggests that the burden of combat-related mental illness from OEF/OIF will be high. Utilization rates for health care and mental health services predict an increasing demand for such services in the future, and evidence suggests that the current wars are presenting new challenges to the DOD and VA health-care systems. Fortunately, Americans are united in agreeing that care for those who have been wounded as a result of military service is a continuing cost of national defense. PTSD, TBI, and other injuries with mental health consequences that are not so easily recognizable can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide, if not treated. We can meet that challenge by ensuring a stable, robust VA health-care system that is dedicated to the unique needs of the nation's veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam and will remain viable for the newest generation of war fighters who will need specialized medical and mental health services for decades to come.

The DOD and VA share a unique obligation to meet the health-care (including mental health care) and rehabilitation needs of veterans who are suffering from readjustment difficulties as a result of combat service or have been wounded as a result of a TBI. Therefore, the DOD, VA, and Congress must remain vigilant to ensure that federal mental health programs are sufficiently funded and *adapted* to meet the unique needs of the newest generation of combat service personnel and veterans, while continuing to address the needs of older veterans with PTSD and other combat-related mental health challenges.

RECOMMENDATIONS:

The IBVSOs recommend that VA work more effectively with the DOD to ensure it establishes a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan obtain effective treatment and follow-up services for war-related mental health problems.

VA must do its part to sustain VA mental health care as a high priority grounded in the principles of the New Freedom Commission on Mental Health. The system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes the guiding beacon for VA mental health planning, programming, budgeting, and clinical care.

Congress should carefully monitor VA's two-year limit on providing start-up funding for new initiatives under VA's National Mental Health Strategic Plan and provide oversight to ensure resources allocated to expand and improve mental health services are used for this express purpose.

The IBVSOs believe more research into the consequences of brain injury and best practices in its treatment is needed and is warranted by VA to deal with both medical and mental health aspects of TBI, including research into the long-term consequences of mild TBI in OEF/OIF veterans, as well as similar injuries in previous generations of combat veterans.

To ensure a smoother transition for veterans with TBI and their caregivers, VA should evaluate ways to provide additional assistance to immediate family

members of brain-injured veterans, including additional resources, improved case management, and continuous follow-up. In this connection we urge VA to implement the family caregiver authorization recently enacted by Congress, Public Law 109-461, at the earliest possible time.

The goal of achieving optimal function of each individual TBI patient requires improved coordination and interagency cooperation between the DOD and VA. Veterans should be afforded the best rehabilitation services available and the opportunity to achieve maximum functioning so they can reenter society or, at minimum, achieve stability of function in an appropriate setting.

The President and Congress should sufficiently fund the DOD and VA to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of older veterans with PTSD and other combat-related mental health challenges.

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Waiver of Health Care Copayments and Fees for Catastrophically Disabled Veterans:

Veterans in priority group 4 should not be subject to copayments.

Veterans meeting the definition of having catastrophic disabilities as a result of nonservice-connected causes and who have incomes above means-tested levels can still enroll in the Department of Veterans Affairs (VA) as priority 4 veterans instead of the less preferential categories 7 and 8. This heightened priority for VA health-care eligibility was granted in recognition of the unique nature of these disabilities and the need for these veterans to avail themselves of the complex specialized health-care services in many cases unique to the mission of the VA health-care system. The higher priority 4 enrollment category would also protect these veterans from not having access to the system were they, under usual circumstances, to be considered in the lower priority categories 7 or 8 if VA health-care resources were to be curtailed.

However, current VA regulation stipulates that even though these veterans are to be considered priority 4 for the purpose of enrollment because of their specialized needs, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. This interpretation violates the intent of the statute in recognizing the unique needs of these veterans and the role of VA in providing their care. These veterans are not casual users of VA health-care services. Because of the nature of their disabilities, they require a lot of care and a lifetime of services. Private insurers do not offer the kind of sustaining care for spinal cord injury found at VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only as well as the best resource for a veteran with a catastrophic disability, yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This puts great financial hardship on these catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. In many instances fees for medical services equipment and supplies can climb to thousands of dollars per year.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet when of a veteran's industry and employ-

ment bring annual income above the means-test levels, he or she is then unduly penalized by exorbitant fees. This "catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

RECOMMENDATION:

Those veterans designated by VA as being catastrophically disabled veterans for the purpose of enrollment in health-care eligibility category 4 should be exempt from all health-care copayments and fees.

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Access Issues

While the Veterans Health Administration (VHA) has made commendable improvements in quality and efficiency, veterans' access to the VA health-care system is severely limited. Excessive waiting times and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

Limited access is the primary problem in veterans' health care. Demand for care at many Department of Veterans Affairs (VA) facilities is straining capacity, and with limited resources, VA has continued to restrict enrollment. Perennially inadequate health-care budgets have resulted in a VA health-care system struggling to meet the needs of our nation's sick and disabled veterans. Without funding to increase clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services and erode the world-renowned quality of VA medical care.

At its peak in July 2002, the VHA had more than 310,000 veterans waiting for medical appointments, half of whom had to wait six months or more for care and the other half having no scheduled appointment. In response, regulations were instituted, and subsequent business practices now allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though VA is committed to providing priority care for veterans of Operations Enduring and Iraqi Freedom and veterans with service-connected disabilities, these actions have not equitably provided timely access to quality heath care for veterans eligible for VA health care under the provisions of the Health Care Eligibility Reform Act of 1996.

To reduce waiting times for sick and disabled veterans seeking care, the Advanced Clinic Access (ACA) Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing outpatient health-care demand, has been implemented and continues to show promise. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system.

We commend Veterans Integrated Service Network (VISN) and facility leadership for their support, which is instrumental in the wide acceptance and success of the ACA initiative. However, their respective performance plans measure waiting times for only 9 clinics, while VHA currently monitors 50 clinics for which its waiting list report captures a large majority of medical appointments made. Such a disparity must be reconciled to ensure sweeping support for the ACA initiative.

Measuring improvement in access to care with wait-time reports is part of this initiative, and in 2004 a change in reporting measurements was established. Operating on the premise that not all veterans waiting six months or greater should automatically be considered delayed because of limited access to care—particularly for such appointments as routine or follow-up care—VA instituted a new standard of measuring waiting times. Waiting times were to be reported on two

veteran patient populations: new enrollees and established patients. Since this change in reporting, *The Independent Budget* veterans service organizations (IBVSOs) have been concerned that a true measurement remains elusive with regard to the demand for medical care and the existing capacity for VA to provide such care. Despite the validation of some aspects of the VA waitlist report for new enrollees, the data remain suspect in light of established business practices of measuring true waiting time, demand, and capacity. In addition, it is a concern that wait list reports have been relegated to providing only "the number of new enrollees waiting for their first appointment where an appointment has not been scheduled," while ignoring a significant portion of the veteran patient population: the established patient.

Despite any measurable improvements in waiting times for needed appointments, continued disparities exist in the implementation of the ACA initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers and growing support from VISNs and facility leadership, success is largely dependent upon the availability of funding. In addition to a fully staffed ACA initiative, the IBVSOs encourage greater support from VA leaders for recommendations made by the ACA initiative toward a more robust tool to accurately measure patient experiences and waiting times, link performance measures to improvements in waiting times, improve decision support by improving clinic efficiency, and compare VHA patients' waiting times with those of private sector patients.

VA's struggle to best capture and measure the veterans' experience in seeking VA medical care with the software system currently in use is clear. While much of the criticism for limited access to VA medical care has been met by the ACA initiative, business processes remain inefficient, primarily due to the aging and cumbersome VistA scheduling software being used to manage appointment activities. The VHA should replace the current scheduling software system to be in line with VA's emerging web-based electronic health system enterprise to provide more comprehensive capacity and demand data to improve resource utilization, to increase provider and patient satisfaction as well as reduce waiting times.

While the IBVSOs believe it is imperative that our government provide a health-care budget that will enable VA to serve the needs of disabled veterans nationwide, both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access and ensure that all service-connected disabled veterans and all other enrolled veterans have access to the system in a timely manner.

RECOMMENDATIONS:

VISNs and facility directors should evaluate whether veterans, as well as the clinics in their area, would benefit from the Advanced Clinic Access Initiative.

The VHA should improve the way it measures administrators' performance on waiting times for appointments.

The VHA should provide the necessary support to implement the Advanced Clinic Access Initiative recommendations for a replacement scheduling software package.

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Community-Based Outpatient Clinics:

Many community-based outpatient clinics (CBOCs) lack staff and equipment to serve the specialized needs of veterans.

The Independent Budget veterans services organizations (IBVSOs) commend Veterans Health Administration (VHA) efforts to expand access to needed primary care services. For many veterans who live long distances from Department of Veterans Affairs medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the need/necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to and shorten waiting times for follow-up care. As VA proceeds in implementing the CBOCs and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will need to enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural areas. VA also needs to enable overcrowded facilities to better serve veterans and must support sharing initiatives with the Department of Defense.

While the IBVSOs support establishment of CBOCs, we remain concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for either the general veteran population or those with service-connected mental illness. To VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health with disease specific documentation. Moreover, too often CBOC staff lack the required knowledge to properly diagnose and treat conditions commonly secondary to spinal card dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care programs.

Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with required accessibility standards in Section 504 of the Rehabilitation Act (29 U.S.C. § 791 et seq.). Regarding physical accessibility to medical facilities, veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the VHA mission to provide health services to veterans with specialized needs. Veterans with specialized needs require primary and preventive care, which in many cases can be appropriately provided in CBOCs that use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VA hospitals and impact in VHA care.

RECOMMENDATIONS:

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting needs of veterans.

The VHA must develop and use clinically specific referral protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in Section 504 of the Rehabilitation Act.

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Veterans' Rural Health Care Access and "Veterans Rural Access Hospitals":

The Department of Veterans Affairs (VA) should work to improve access to VA health-care services for veterans living in rural areas.

The Independent Budget veterans service organizations (IBVSOs) believe that after serving their country, veterans should not see their health-care needs neglected by VA because they choose to live in rural and remote areas far from major VA health-care facilities.

We have gathered some pertinent findings dealing with rural veterans in general as well as newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). For example, one in five veterans nationwide who is enrolled to receive VA health care lives in a rural area. *(Am. J. Pub. Health,* Oct. 2004). Likewise 44 percent of today's active duty military service members and tomorrow's veteran population list rural communities as their homes of record.

Also, from other studies we are able to provide insight on the special, and even unique, needs of rural veterans:

- Veterans who live in rural settings are older and have more physical and mental health diseases compared to veterans who live in suburban or urban settings. *(Am. J. Pub. Health,* Oct. 2004)

- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive compensation. *(Am. J. Pub. Health,* Oct. 2004)

- According to "The Future of Rural Health," report, "the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services." ("Quality Through Collaboration: The Future of Rural Health," Institute of Medicine, Committee on the Future of Rural Health Care, 2005)

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for suicide, stress, depression, and anxiety disorders as major rural health concerns. ("Rural Healthy People 2010," Vol. 2, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)

- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas. (President's New Freedom Commission on Mental Health, Final Report, July 2003)

- Nearly 22 percent of our elderly live in rural areas. Rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care. ("Rural Healthy People 2010," Vol. 3, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)

Without question, section 212 of Public Law 109-461, signed into law by the President on December 22, 2006, is the most significant advance to date to address health-care needs of veterans living in rural areas. Under this legislation, VA must establish a new Office of Rural Health within the Veterans Health Administration. This office must carry out a series of requirements in an effort to improve VA health care for veterans in rural and remote areas. This legislation is also aimed—of particular importance—at better addressing the needs of returning veterans who have served in Iraq and Afghanistan. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in these communities. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and the National Guard to ensure that returning veterans and Guard members who, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. The legislation also requires an extensive assessment of the existing VA fee-basis system of contract care and

the development of a plan to improve access and quality of care for enrolled veterans in rural areas.

Although the authors of *The Independent Budget* acknowledge this legislative measure will be beneficial to veterans living in rural and remote areas, the legislation also raises potential concerns about the unintended consequences it may have on the mainstream VA health-care system. As we indicate elsewhere in this *Independent Budget,* in general, current law places limits on VA's ability to contract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban. The IBVSOs believe VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health care programs only exacerbates the problems currently encountered.

VA has had continuing difficulty securing sufficient funding through the Congressional discretionary budget and appropriations process to ensure basic and adequate access for the care of sick and disabled veterans. Congress repeatedly has been forced to add additional funds to maintain VA health-care services. Also, VA receives no Congressional appropriation dedicated to support the establishment of rural community-based outpatient clinics or to aid Veterans Rural Access Hospital (VRAH)–designated facilities, and thus VA must manage any additional expenses from within generally available Medical Services appropriations. VA has established and is operating more than 711 community-based outpatient clinics, of which 100 are located in areas considered by VA to be rural or highly rural. Given current financial circumstances, we are skeptical that VA can cost-effectively justify establishing additional remote facilities in areas with sparse veteran populations.

Under the federal Medicare program, a critical access hospital (CAH) is a private hospital that is certified to receive cost-based reimbursements from Medicare. The higher reimbursements that CAHs receive under this program compared to urban facilities are intended to improve their financial security and thereby reduce rural hospital closures. In other words, the federal policy is to financially aid struggling rural hospitals in hopes that they will survive. Also CAH facilities are certified under Medicare "conditions of participation" that are more flexible than those used for other acute care hospitals. As of March 2006 [the latest data available], there were 1,279 certified CAH facilities in rural and remote areas.

As a part of the CARES initiative, VA employed Medicare's CAH model as a guide to establish a new VA policy to govern operations of, and planning for, many of VA's rural and remote facilities, now designated VRAH. In 2004, however, the CARES Advisory Commission questioned whether VA's policy was adequate and recommended VA "...establish a clear definition and clear policy on the CAH [now VRAH] designation prior to making decisions on the use of this designation."

Following this guidance from the CARES Commission, on October 29, 2004, VA issued a directive [still in force] that sets a significant number of parameters for VRAH designation, but seems pointed in a direction opposite from that of Medicare for the CAH facilities in the private sector. Illustrative is the basic definition of VRAH, as follows:

> "A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or

other specialized care not available at the rural facility. The facility should be part of a system of primary health care (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc." (VHA Directive 2004-061, October 29, 2004)

We believe VA must carefully monitor the scope of services performed at its smaller, rural facilities, specifically for those procedures that are complex in nature. Further, as medical care advances in the use of high technology and thereby elevates the standard of care, small VA inpatient facilities may find it increasingly difficult to effectively maintain, and actually use these new tools, to provide health care at its most sophisticated levels. However, we believe VA must maintain a safe and high-quality health-care service within each of its facilities, and to the greatest degree possible offer comprehensive care to veterans at each of its facilities, whether rural, suburban, or urban.

The IBVSOs remain concerned about whether VA's VRAH policy fully considers the implications of large-scale referrals from rural VA medical centers in continuing to provide high quality health care in those locations, particularly when veterans are referred to other far off medical centers within a Veterans Integrated Service Network or to private facilities. VA must also consider patient satisfaction, family separation, and travel burdens in the criteria they use for determining which rural facilities should retain acute care services. If acute care beds are to be retained in one facility because of distances that veterans must travel to access inpatient care or receive specialized services, we believe this logic should be standardized and used systemwide to the greatest extent possible.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA's vet centers.

Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling for military-related trauma. Building on the strength of the Vet Centers program, VA should be required to establish a pilot program to have mobile Vet Centers that could help reach veterans in rural and remote areas.

The new legislation holds VA accountable for improving access for rural veterans through CBOCs and other access points by requiring VA to develop and implement a plan for improving veterans' access to care in rural areas. The May 2004 Secretary's CARES decision identified 156 priority CBOCs and new sites of care nationwide. The VA Secretary is also required to develop a plan for meeting the long-term and mental health care needs of rural veterans. We urge Congress to include funding in fiscal year 2008 to specifically support at least some of these needs in rural areas.

Health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. "The Future of Rural Health" report cited previously recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deeper involvement in health professions education of future rural clinical providers seems essential in improving these situations in VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their health personnel needs.

Helping homeless veterans in rural and remote locations recover, rehabilitate, and reintegrate into society is complex and challenging. VA has no specific programs to help community providers who focus on rural homeless veterans. The rural homeless also deserve attention from VA to aid in their recoveries.

Likewise, Native American, Native Hawaiian, and Native Alaskan veterans have unique health-care needs that VA needs to address with outreach and other activities.

Rural veterans, veterans service organizations, and other experts need a seat at the table to help VA consider important program-and-policy decisions, such as those described here, that would have positive effects on veterans who live in rural areas. The final legislative language of Public Law 109-461 failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans, and other rural experts to recommend policies to meet the challenges of veterans' rural health care. We are disappointed that Congress did not include this requirement in law, but the Secretary of Veterans Affairs retains the authority to establish such a committee. The IBVSOs urge the Secretary to take this action.

RECOMMENDATIONS:

VA must ensure that the distance veterans travel, as well as other hardships they face be considered in VA's policies in determining the appropriate location and setting for providing VA health-care services.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reductions in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

Mobile Vet Centers should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and remote areas.

Through its affiliations with schools for the health professions, VA should develop a policy to help supply health-professions clinical personnel to rural VA facilities and to rural areas in general.

VA must focus some of its homeless veteran program resources, including contracts with, and grants to, community-based organizations, to address the needs of homeless veterans in rural and remote areas.

VA rural outreach should include a special focus on Native American, Native Hawaiian, and Native Alaskan veterans' unmet health-care needs.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee, to include membership by the veterans service organizations among those that have offered this *Independent Budget*.

VHA-DOD Sharing:

The Independent Budget ***encourages collaboration between Department of Veterans Affairs (VA) and Department of Defense (DOD) health care and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.***

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. The United States Constitution, Article I, Section 8 requires Congress: "To raise and support Armies...To provide and maintain a Navy...[and] To make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers..." Additionally, federal law (38 U.S.C. § 8111(a)) states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly[.]."

However, there appear to be a number of gaps in what is required by statute and what actually occurs. In a report released in January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance (The Principi Commission) addressed the need for greater sharing between VA and the DOD. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), created by Executive Order in May 2001, was asked to:

- "identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;
- review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure."

The Capital Asset Realignment for Enhanced Services (CARES) Commission report of February 12, 2004, states: "Over the past decade, a number of commissions, advisory organizations, and the General Accounting Office [now the General Accountability Office] have studied various approaches to providing quality health care to veterans. One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DOD."

Presidential Review Directive 5 of August 1998 requires VA and the DOD to develop a computer-based patient record system that would accurately and efficiently exchange information between the departments. Eight years later the envisioned system still remains a challenge.

It is time to stop doing studies, writing reports, and taking minimal action. In this time of tight funding and a war against world terrorism, it is imperative that VA and the DOD begin implementing many of the recommendations made by these various reports, as well as take further actions to foster VHA-DOD sharing.

The IBVSOs continue to support the careful expansion of VA-DOD sharing agreements. However, we concur with the statement of Dr. C. Ross Anthony (one of the PTF commissioners) before the House Committee on Veterans' Affairs in June 2003, when he said that the PTF "concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, the DOD appears at present to have adequate funding to fulfill its health-care responsibilities. As this committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully, in a manner that creates incentives for efficiency." VA and the DOD will not be able to accomplish either their mandated or recommended sharing goals until Congress addresses the mismatch between the veterans' demand for services and the appropriated resources made available to the Veterans Health Administration of VA.

■ Leadership and Reporting

The VA-DOD Joint Executive Council should report, at least annually, to the House Committees on Armed Services and Veterans Affairs on collaborative activities, including development of tools to measure outcomes

relating to access, quality, cost, and progress toward meeting goals set for collaboration, sharing, and outcomes. Not only do the IBVSOs believe that there has been insufficient transparency in the work of various DOD and VA executive planning forums, but we also believe that without direct guidance from the respective Secretaries, to include responsibility and accountability of local management personnel, these sharing agreements are doomed to failure. This has also been announced as the viewpoint of the previous Chairman of the House Committee on Veterans' Affairs.

It has been noted, specifically in GAO report GAO-06-794R, that rather than resolve the issues pertaining to various proposed joint-sharing programs, the DOD prefers to "throw stones" at the GAO and VA. The DOD refuses to acknowledge, citing the Health Insurance Portability and Accountability Act, that the health-care and medical records of our veterans and service members fall under the purview of both the DOD and VA. In this report, the DOD admonishes VA for a security breach resulting in the loss of a laptop with 28.6 million files on it. In actuality, from February 15, 2005, to November 3, 2006, VA had six security breaches that affected millions of veteran records. At the same time, the DOD had 10 breaches that affected millions of service member records (Privacy Rights Clearinghouse).

Neal P. Curtin, director, Operations and Readiness Issues, General Accountability Office, stated, in GAO Letter GAO-04-292R to the Chairman of House Committee on Veterans' Affairs, "VA and DOD have been pursuing ways to share in their health information systems and create electronic records since 1998...." They still haven't accomplished that goal. Without the successful electronic integration of health-care information, neither "seamless transition" nor joint ventures will be successful. The CARES Commission report states: "At those locations where collaboration was not successful or where it had been proposed for some time but had not gained momentum, the Commission found...no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration."

From its review, the commission concluded that to ensure a successful collaborative relationship between the DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

To this end, the IBVSOS believe that sharing agreements should be negotiated and written by local leadership, as they are now, but when ready for signature, they should be signed by the VA Under Secretary for Health and the appropriate service Secretary. This would preclude future local management personnel from repudiating the agreements.

The Departments signed a memorandum of agreement (MOA) November 17, 2004, concerning Cooperative Separation/Process Examinations. However, this MOA simply allows only the local Veterans Affairs medical center and military treatment facility (MTF) at benefits delivery at discharge sites to sign individual memorandums of understanding (MOU). According to the appendices to the MOA, this will be require 138 separate MOUs be negotiated and signed.

■ Joint Venture Sites

The DOD and VA have identified 74 sharing initiatives at the facility level, 35 of which appear promising to VA. The DOD has identified 20 and VA has identified 21 of these as priority initiatives. In addition, the DOD and VA announced, in October 2003, a series of demonstrations, required by P.L. 107-314, to test improving business collaboration between the DOD and VA health-care facilities. The Departments will use the demonstration projects at eight locations to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. *The Independent Budget* does not object to these ventures, but we do have serious concerns about maintaining an independent presence in serving enrolled veterans as its top priority.

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES decision, released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military

installations will go into "lock down" status. This would effectively deny Veterans Health Administration (VHA)–enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA universal identification card for access to the installation and issue a vehicular decal to VHA patients. Currently, the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. A fifth color could be used for VHA patients.

Of the 21 sites identified by VA as primary joint venture locations, only two have been opened: Bassett ACH, Alaska, and Patterson ACH, New Jersey. However, Patterson ACH is a joint venture with Fort Monmouth, New Jersey. The 2005 Base Realignment and Closure recommended Fort Monmouth be closed. Of the two joint venture clinics in Puerto Rico, one was to have been in conjunction with Naval Hospital Roosevelt Roads, which was closed in 2004. Of the remaining 19 sites, 2 were heavily damaged by Hurricane Katrina, and, to the best of our knowledge, only the VAMC North Chicago-USNACC Great Lakes project is being implemented. Of the other 16 sites, 9 of them could result in veterans being denied health care during increased force readiness conditions.

■ VA and DOD Access Standards

VA has had access standards since 1995, but *these standards have not been enforced*. The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demand for care at MTF and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive "full funding to meet demand, within access standards[.]" PTF Report at 81.

■ Fully Funded Enrolled Veterans

The PTF recommended that the "Federal Government should provide full funding to ensure that enrolled veterans...are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.]" PTF Report at 77.

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and by sustaining*, VA health-care funding. As outlined elsewhere, *The Independent Budget* strongly recommends mandatory funding for all enrolled veterans for whom the Secretary has directed care be provided.

The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

RECOMMENDATIONS:

Congress should provide the necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions to be made more expeditiously.

Congress should provide sufficient resources to enable the DOD and VA to enhance information management interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in Title 38 United States Code.

Congress should mandate that all interdepartmental agreements between departments of the executive branch be approved/signed off at the Under Secretary level or higher.

Congress should mandate that, in the case of joint health-care facilities operated by the DOD/VA, procedures be implemented to preclude the loss of health care to veterans in case of an increased force protection condition.

Congress should mandate that, in locations where VA-DOD joint-sharing agreements exist, in event of involuntarily dissolution due to a base realignment and closure, VA be completely funded to assume total control of the facility or facilities.

Congress should require mandatory funding of VA health care.

Priority 4 Veterans

Classification of Priority 4 Veterans Remains a Problem:

Catastrophically disabled veterans may be incorrectly classified and, as a result, denied care within the Department of Veterans Affairs (VA) health-care system. Current benefits for the catastrophically disabled veteran should be enhanced.

Reports of catastrophically disabled veterans being denied care still persist. VA has acknowledged Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4. However, after nine years, the Veteran's Health Administration (VHA) has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them.

Individual requests are processed when brought to the attention of the VA; however, national service officers still experience some reluctance when requesting a reclassification. This has a direct effect on those with new injuries and those who have not enrolled in the VA health-care system. Many of these veterans may have been classified as a priority 8 prior to the injury, and now when they need the services of the VA, may be denied care as they are not accepting priority 8 veterans. This is further affected by concerns for future VA reductions in priority levels which could result in denied care for the catastrophically disabled veteran.

Currently, priority group 4 includes veterans granted VA Aid and Attendance (A&A) or Housebound benefits and veterans who are determined by VA as "catastrophically disabled." Those veterans determined as "catastrophically disabled" who are not otherwise exempt from copayments and/or eligible for beneficiary travel benefits are still required to make applicable copayments for medical care and medications and/or denied beneficiary travel assistance. The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the families who may be responsible for his or her care. At a time when a veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be "catastrophically disabled" and placed in the priority group 4 should be afforded the same benefits as if rated as entitled to A&A to eliminate medical/prescription copays and provide assistance with travel for that care.

RECOMMENDATIONS:

The VHA should develop a program to identify veterans with disabilities as defined in PL 104-262 and properly classify them as priority 4.

The VHA should report to Congress the number of veterans reclassified as a result of PL 104-262.

VA should, based on a catastrophic disability determination, exempt all enrollment priority group 4 veterans from copayments and provide them with the medical and travel benefits that are due a veteran who is entitled to A&A.

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Non-VA Emergency Services:

Enrolled veterans are being excluded from non–Department of Veterans Affairs (VA) emergency medical services as a result of established eligibility restrictions.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance coverage and experience a medical emergency. Under this benefit, VA will pay for services rendered to a veteran who is found eligible and files a claim for payment for emergency treatment received from a private facility. However, some veterans' claims are denied payment due to the restrictive nature of the eligibility criteria.

To qualify under this provision, a veteran must be enrolled in the VA health-care system and must have been seen by a VA health-care professional within the 24 months prior to the emergency. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The Independent Budget veterans service organizations object to eligibility limitations on enrolled veterans: All enrolled veterans should be eligible for VA payment of emergency medical services provided at non-VA medical facilities.

The frequency with which VA denies payment for the emergency care veterans receive, and who are then held liable by the private facilities, is alarming. In addition to denial by eligibility requirements, VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to receive emergency care at a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., "esophogitis," rather than the admitting diagnosis, e.g., "chest pain." Veterans should not be penalized for seeking emergency care when experiencing symptoms that they believe manifest a life-threatening condition.

RECOMMENDATIONS:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish and enforce a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a life- or health-threatening medical emergency.

Rather than an arbitrary medical contact requirement, veterans' enrollment should govern VA's policy of reimbursement for emergency medical services in private facilities.

VA should establish a policy consistent with these recommendations that would appropriately allow all enrolled veterans to be eligible for emergency medical services when needed.

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SPECIALIZED SERVICES

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Centralized prosthetic and sensory aids funding for the Department of Veterans Affairs (VA) has been an improvement; however, veterans continue to encounter problems in the timely distribution of service and equipment. Program enhancements have been developed to eliminate or minimize obstacles; however, they have not been fully implemented throughout the VA health-care system.

The protection of these funds by a centralized budget for prosthetics has had a major positive impact on disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetics needs of veterans with disabilities.

The IBVSOs also are in full support of the decision to distribute FY 2007 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget-reporting process.

The IBVSOs believe the requirement for oversight of the expenditures of centralized prosthetics funds has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs continue to applaud senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2007. The present 2007 allocated budget for prosthetics is $1,231,512,000. Funding allocations for FY 2007 were primarily based on FY 2006 NPPD expenditure data, coupled with Denver Distribution Center billings, and other pertinent items. The VHA also looked at VISN requests, past accuracy between request and expenditures, and new programs being established. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

It is anticipated that, $1,339,131,000 will be required to cover the FY 2008 prosthetics budget. This is a result of advancements in prosthetics technology, telehealth, and the increase in unique health-care issues of veteran patients who require specialized prosthetics needs.

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Listed on the next page are examples of NPPD expense costs in fiscal year 2006 with projected expense costs for fiscal year 2007.

NPPD EXPENSE COSTS

Prosthetic Item	Total Cost Spent in FY 06	Projected Expenditure in FY 07
Wheelchairs & Access	$ 129,506,709	$ 140,636,876
Artificial Legs	$ 69,144,331	$ 75,086,787
Artificial Arms	$ 3,438,282	$ 3,733,778
Orthosis/Orthotics	$ 32,929,691	$ 35,759,760
Shoes/Orthotics	$ 26,738,433	$ 29,036,408
Sensori-Neuro Aids	$ 56,311,246	$ 61,150,791
Restorations	$ 3,003,352	$ 3,261,468
Oxygen & Respiratory	$ 156,873,103	$ 170,355,215
Medical Equipment & Supplies	$ 133,657,071	$ 145,143,932
Home Dialysis	$ 1,298,507	$ 1,410,104
HISA	$ 6,235,912	$ 6,771,844
Surgical Implants	$ 340,735,579	$ 370,019,344
Other Items	$ 147,667,468	$ 189,145,693
Total Spent	**$ 1,107,539,684**	**$ 1,231,512,000**

RECOMMENDATIONS:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including covering the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the NPPD.

VHA senior leadership should continue to hold its field managers accountable for failing to ensure that data are properly entered into the NPPD.

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Assessment of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

National contracts for single-source prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic

devices. Mainly our concern lies with the high compliance rates that are contained in the national contracts. The typical compliance rate, or performance goal, in the national contracts awarded so far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple-sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from the VHA's standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA routinely purchases threatens future advances. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market.

Another problem with the issuance of prosthetic items relates to surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stints, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are limiting the number of surgeries due to the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

RECOMMENDATIONS:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.

Restructuring of Prosthetics Programs:

The prosthetics program continues to lack timely and consistent service to the patients.

The Independent Budget veterans service organizations (IBVSOs) believe Veterans Health Administration (VHA) headquarters must provide more specific information and direction to Veterans Integrated Service Networks (VISNs) on the restructuring of their prosthetics programs. The current organizational structure has communication inconsistencies that have resulted in the VHA central office trying to respond to various local interpretations of Department of Veterans Affairs (VA) policy.

■ **VHA HEADQUARTERS MUST DIRECT VISN DIRECTORS TO:**

- Designate a qualified VISN prosthetic representative who will be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, and guidelines on all issues of interpretation of the prosthetics policies.
- Ensure that the VISN prosthetic representative has direct input into the performance evaluation of all prosthetics full-time employees at local facilities that are organized under the consolidated prosthetics program or product line.
- Ensure that the VISN prosthetic representative not have collateral duties as a prosthetic representative for a local VA facility within his or her VISN.
- Establish a single VISN budget for prosthetics and steps taken to ensure that the VISN prosthetic representative has control of and responsibility for that budget.
- Establish time limits for prosthetic denials in order to expedite the appeal process.

RECOMMENDATIONS:

The VHA must require all VISNs to adopt consistent operational parameters and authorities in accordance with national prosthetics policies. VISN directors as well as VHA central office staff should be held responsible for implementing a consistent prosthetics program that reduces the need for central office intervention. Time limits for denial of prosthetics requests should be established and adhered to.

The VHA should establish a time limit for denials of prosthetic requests.

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Failure to Develop Future Prosthetics Staff:

There continues to be a shortage in the number of qualified prosthetics staff available to fill current or future vacant positions.

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetic Representative Training Program projected in fiscal year 2007 and 2008. Interns in this program are invited to the annual National Prosthetic Representative Training Conference for a one-week intense prosthetics forum. In fiscal year 2005, trainee recruitment for the program was suspended by the Technical Career Field (TCF) per request of the National Leadership Board (NLB). It was reestablished in 2006 and 2007. *The Independent Budget* veterans service organizations (IBVSOs) would like ensure that this training program be established on a permanent basis.

This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetic representative positions. There are some VISNs who have developed their own Prosthetic Representative Training Program.

These VISN interns are included in the annual National Prosthetic Representative Training Conference. The IBVSOs recommend that all VISNs have a Prosthetic Representative Training Program to enhance the quality of health-care service within the VHA system. The IBVSOs believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients.

We are seeing an increasing number of injuries as a direct result of Operation Enduring Freedom and Operation Iraqi Freedom, and our returning military personnel are being issued complex technological prosthetic devices. Each major prosthetics department within the VA must have trained certified technologists that can maintain and repair these devices.

RECOMMENDATIONS:

The VHA must fully fund and implement its National Prosthetic Representative Training Program on an ongoing basis, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids. Sufficient training funds and employee staff must be dedicated to this program to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that selected candidates for vacant VISN prosthetic representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that prosthetics departments are staffed by certified professional staff that can maintain and repair the latest technological prosthetic devices.

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Hearing Loss and Tinnitus:

The Veterans Health Administration (VHA) needs to provide a full continuum of audiology services.

While loud noise has been part of military life since muskets and cannons were part of the arsenal, Iraq is proving one of the noisiest battlegrounds yet. Roadside bombs—the signature weapon of the country's insurgency—regularly hit patrols, popping eardrums in their wake.

According to Veterans Affairs' (VA) data, major hearing loss disability cases held steady through the late 1990s. The number rose markedly from nearly 40,000 cases in 2002 to about 50,000 in 2005, the latest year for which data were available. In 2005 the Department of Veterans Affairs spent nearly $800,000 treating major hearing loss—a nearly 20 percent jump from 2004.

■ Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen by a physician and are often easily diagnosed and treated. Many soldiers exposed to blasts from roadside bombs suffer internal injuries that are not as easy to detect and treat. One of the most prevalent disabilities from exposure to IEDs (improvised explosive devices) is an injury that is one of the hardest to detect—and even harder to treat. Soldiers may even be unaware of this injury upon separation from the military. It is called tinnitus.

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some with tinnitus describe it as "ringing in the ears," but people

report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 30 million, or more, people in the United States to some degree. Ten to 12 million are chronically affected and 1 to 2 million are incapacitated by their tinnitus (Brown et al., 1990). It is estimated that 250 million people worldwide experience tinnitus (Holme et al., 2005).

■ Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for their tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5 years. From 2004 to 2005, the number of veterans receiving compensation for their tinnitus increased by 20 percent. That's the single largest one-year increase since tinnitus became compensable in 1945. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $115 a month. Though it is considered to be a "disease of the ear" according to Title 38 of United States Code (the veterans disability rating handbook), only one "ear" is considered in determining disability rating for tinnitus.

Translated into economic terms, the government paid out nearly $418 million in disability compensation for tinnitus in 2005. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1 billion for fiscal year 2005 alone. If tinnitus continues on the upward trend seen over the past five years, which is an average annual rate of $53.6 million, the cost to taxpayers for tinnitus disability claims will reach $1.2 billion by 2025. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint.

■ Noise-Induced Hearing Loss and Tinnitus

Although tinnitus has a number of different causes, one of the primary causes among military personnel is noise exposure. Service members are exposed to extreme noise conditions on a daily basis during both war and peace time. During present day combat, a single exposure to the impulse noise of an IED can cause tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can either be a single burst or multiple bursts of energy. Most impulse noises, such as the acoustic energy emitted from an IED, occur within one second. However, successive rounds of automatic weapon fire are also considered impulse noise.

According to the National Institute on Deafness and other Communication Disorders (NIDCD), any sounds that emit noise of 80 decibels (dBA) or higher can cause tinnitus and hearing damage. Prolonged exposure from sounds at 85+ dBA can also be damaging, depending on the length of exposure time. As decibel levels intensify, the time an individual needs to be exposed decreases and the chance of noise-induced hearing loss and tinnitus increases. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The table below shows a few common military operations and their associated noise levels.

NOISE LEVELS–COMMON MILITARY OPERATIONS

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105 mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 feet from target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

Source: U.S. Army Center for Health and Preventative Medicine, http://chppm-www.apgea.army.mil/

It's no surprise that service members using weaponry that emits such high decibel levels, in training or combat, are at greater risk of this type of disability than the general U.S. population. So what's being done to help our military? Hearing conservation programs have been in place since the 1970s to protect and preserve the hearing of our soldiers. However, a study released by the Institute of Medicine in 2005 reviewed these hearing conservation programs and concluded they were not adequately protecting the auditory systems of service members.

Additional studies conducted to assess the job performance of those exposed to extremely noisy environments in the military concluded that the noise not only caused disabilities, but put the overall safety of the service member and their team at risk. Reaction time can be reduced as a result of tinnitus, thus degrading combat performance and the ability to understand and execute commands quickly and properly.

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in "Tank Gunner Performance and Hearing Impairment" (Garinther & Peters, *Army RD&A Bulletin* 1990) concluded that hearing impairments may delay a soldier's ability to identify his or her target by as much as 50 seconds.

The same study concluded that those with hearing impairments who were operating tank artillery were 36 percent more likely to hear the wrong command, and 30 percent less likely to correctly identify their target. Further, the authors noted that soldiers with hearing impairments only hit the enemy target 41 percent of the time, while soldiers without hearing impairments hit the enemy target 94 percent of the time. Finally, the article stated that those with hearing impairments were 8 percent more likely to take the wrong target shot and 21 percent more likely to have their entire tank crew killed by the enemy. According to the study's authors, hearing impairments, such as tinnitus, can very much be a life-or-death situation in the military.

■ The Role of Medical Research

Research has increased our knowledge on hearing loss and how the ear loses the ability to hear, while less has been discovered about tinnitus. We do know that tinnitus is a condition of the auditory system. The sound a person hears is actually generated in the brain. This raises another question of possible correlation to another injury that has seen a recent increase. Traumatic brain injuries (TBIs) have been on the rise as more and more soldiers have been exposed to IEDs. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries *(National Geographic,* Dec. 2006).

Since tinnitus is something that happens in the brain, could there be a correlation between tinnitus and TBIs? It's a question that will remain unanswered unless the federal government funds more medical research as encouraged by *The Independent Budget* veterans services organizations (IBVSOs).

In FY 2005, VA funded about $4.4 million in auditory research. About one-tenth of that was spent on clinical research to learn best practices for treating veterans with tinnitus. Based on evidence from VA data, an audiological evaluation should be mandatory upon separation from the military.

Even though tinnitus research has come a long way, especially in recent years, we need to know much more. With so many veterans being added to the rolls every year for service-connected tinnitus, VA and the DOD should be emerging as leaders in tinnitus research.

The total number of veterans disabled for hearing loss and tinnitus: 414,025 veterans were disabled for hearing loss; 339,573 veterans were disabled for tinnitus. In total, 753,598 veterans were disabled for hearing loss or tinnitus.

RECOMMENDATIONS:

The VHA must rededicate itself to the excellent of program for hearing loss and deficiency.

The VHA must continue its work with networks to restore clinical staff resources in both inpatient and outpatient audiology programs.

Congress must continue to work for increased funding for VA and the DOD to prevent and treat tinnitus.

Blinded Veterans:

The Veterans Health Administration (VHA) needs to provide a full continuum of vision rehabilitation services.

The Department of Veterans Affairs (VA) Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) located across the country with plans for three new BRCs. Approximately 44,438 blind veterans were enrolled in FY 2005 with the visual impairment service team (VIST) coordinators offices, and projected demographic data suggest that by 2009 the VA system could realize an increase to approximately 53,000 enrolled blind and visually impaired veterans requiring services.

The Independent Budget veterans service organizations (IBVSOs) emphasize that data compiled between March 2003 and April 2005 by the Department of Defense (DOD) show that **16 percent** of those evacuated from Iraq have eye injuries. As of August 2006, Walter Reed Army Medical Center has surgically treated approximately 670 soldiers with either blindness or moderate to severe significant visual injuries. The National Naval Medical Center has a list of more than 350 veterans with eye injuries that will require surgery. Approximately 40 of these service members have received treatment at the 10 VA BRCs while others are in the process of being referred for admission. Nevertheless, we fear that many are unaccounted for and lost in the DOD system and that the BVA has found some in medical hold companies that had never been referred to the VA BRS. With some 22 percent of the wounded being Army National Guard or Reserves, *The Independent Budget* veterans service organizations are concerned that many others who could benefit from VA rehabilitative services are being lost in the seamless transition process, and we request that Congress exercise greater oversight on the lack of tracking of these eye-injured service members from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

As of January 14, 2006, the DOD had reported more than 11,852 returning wounded service members had suffered exposure to blast injuries, the most common being from improvised explosive devices (IEDs). Traumatic brain injury (TBI) has become the "signature injury" of OEF and OIF. Blast-related injury is now the most common cause of trauma in Iraq. A recent study found that 88 percent of military troops treated at an echelon II medical unit in Iraq had been injured by IEDs, and 47 percent of those suffered TBI. Data from screening of 7,909 marines with the 1st Marine Division revealed that 10 percent suffered from TBI 10 months after returning from Iraq. At Fort Irwin, 1,490 soldiers were screened in May of 2006, and almost 12 percent of them had suffered concussions resulting in mild to moderate TBI injuries.

More than 1,750 of the total of service members with TBI have sustained severe enough TBI to result in neurosensory complications, with epidemiological TBI studies finding that 24 percent have associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, and inability to interpret print, with some TBIs resulting in legal blindness and other manifestations known as post-trauma vision syndrome. *The Independent Budget* fully endorsed the increased funding of $19 million for the Defense and Veterans Brain Injury Center for FY 2007 and supports increases in FY 2008 to meet new injuries. According to a recent study by researchers at Harvard and Columbia, it is estimated that the cost of medical treatment for service members with TBI will be at least $14 billion over the next 20 years. The current discretionary budget process does not address this issue.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. As the VHA made the transition to more outpatient primary care systems of healthcare delivery in the 1990s, the BRS failed to make the same transition for blind rehabilitation services for veterans. During Congressional testimony on July 22, 2004, the Government Accountability Office recommended that the VA BRS expand its capacity to provide a full continuum of blind rehabilitation services. This has not occurred because of a lack of overall funding. By the VHA's own estimates, it needs $14.4 million to implement the full continuum of rehabilitative care. At present, approximately 1,200 blinded veterans are waiting an average of 24 weeks for entrance into 1 of the 10 VA BRCs. Under the present system, many older veterans will not attend a residential BRC—so they do not receive any type of rehabilitation.

The Independent Budget encourages directed funding of an additional $9.6 million in FY 2008 for new models of blind rehabilitation outpatient services. By encompassing the full spectrum of visual impairment services—blind rehabilitative outpatient specialists (BROS), Visual Impairment Center to Optimize Remaining Sight a specialized low vision optometry program, and the Visual Impairment Services Outpatient Rehabilitation Program—all the various outpatient programs could screen those service members with high risk or history of TBI for neurological visual complications that might otherwise be undiagnosed—plus be effective outpatient programs for the aging population requiring outpatient services.

Now is the time for implementation of the full continuum of outpatient services for all visually impaired veterans. Congressionally mandated BRS capacity must be maintained. BRS continues to suffer losses in critical full-time employee equivalents, compromising the BRS's capacity to provide comprehensive residential blind rehabilitation services with some of the blind rehabilitation centers operating at only 82 percent of all of their beds because of staff reductions caused by overall funding shortages. Other critical BRS positions, such as full-time VIST coordinators and the current 26 BROS, must be increased and are necessary for the four polytrauma centers and the 17 secondary polytrauma centers. Blind rehabilitative outpatient specialists (BROS), in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, also provide blind rehabilitation training in veterans' homes. They also assist in follow-up training when veterans return from a blind rehabilitation center.

RECOMMENDATIONS:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must rededicate itself to the excellence of the full continuum of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

VHA headquarters must undertake aggressive oversight and allocate an additional $9.6 million to ensure the full continuum of care for blind services.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff and disputes must be elevated to the Under Secretary for Health for resolution.

Spinal Cord Dysfunction:

Quality health care delivered to the patient with spinal cord dysfunction continues to be hindered by the lack of qualified staff to support the mission of the Spinal Cord Injury/Spinal Cord Dysfunction (SCI/D) program.

■ SCI/D LEADERSHIP

Several major SCI/D programs are under "acting" management, with a serious shortage of qualified, board-certified SCI physicians. The shortage of qualified board-certified SCI physicians has resulted in delays in policy development and a loss of continuity of care.

It must be recognized that SCI medicine is a major subspecialty and clinical leadership of these departments is as vital to the Department of Veterans Affairs (VA) health-care program as the specialties of general medicine and surgery. Vacancies, specifically in chief positions, reflect adversely on the management of the local VA hospital and the Veterans Health Administration (VHA) system of care. It can be assumed that either the hiring process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

■ NURSING STAFF

VA is beginning to experience delays in admission and bed reductions based upon availability of qualified nursing staff. *The Independent Budget* veterans service organizations (IBVSOs) continue to agree that basic salary for nurses who provide bedside care is not competitive with community hospital nurses. This results in high attrition rates as these individuals leave the VA for more attractive compensation in the community.

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and the morale of the nursing staff. Unfortunately, facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budget.

■ PATIENT CLASSIFICATION

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system, is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or the year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the patient with SCI/D. According to the *California Safe Staffing* Law, dealing with registered nurses to patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2005-001. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2006, nurse staffing was 1,297.7. This number is 49.9 FTEEs short of the mandated requirement of 1,347.6. The 1,297.7 FTEEs includes nursing administrators and non-bedside RNs (79.5) and light duty staff (35). Removing the administrators and light duty staff makes the total number of nursing personnel at 1,183.2 FTEEs to provide *bedside nursing care.*

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 515.6 RNs working in SCI/D. Out of that, 79.5 are in non-bedside or administrative positions, leaving 436.1 RNs providing bedside nursing care. With 1,297.7 nursing personnel and 515.6 of those RNs, this leaves an RN ratio of 40 percent to provide *bedside nursing care.* If the non-bedside RNs were excluded, the percentage of RNs drops to 36 percent. These numbers are well below the mandated 50 percent RN ratio.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has manifested itself by VA facilities beginning to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

RECOMMENDATIONS:

The VHA should authorize substantial recruitment incentives and bonuses to attract board-certified physicians for staff as well as the SCI chief position.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

Gulf War Veterans:

Gulf War veterans still suffer from illnesses related to their military service.

In the 15 years since the Gulf War, both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have seen many service members and veterans who participated in the Gulf War and have concerns regarding chronic illnesses and disabilities possibly related to their military service. The controversy over "Gulf War syndrome" still exists, but it is clear that many Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain.

Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf War veterans suffer from real illnesses, there is no syndrome, single disease, or medical condition affecting them. Some progress has been made in focusing and managing research by both departments, but there is room for improvement, particularly when laboratory and research findings offer improved clinical care and new therapies for Gulf War veterans.

We are concerned that the current conflict in Iraq has, once again, placed our ground troops fighting and living in the same areas as Gulf War veterans did. VA's response to this unique situation was to broaden the scope of Gulf War illness research to include "deployment related health research." In reviewing VA-funded research on Gulf War illnesses, the Research Advisory Committee on Gulf War Veterans' Illnesses has raised questions on the nature of some VA-funded research as to whether these research projects will directly affect veterans suffering from Gulf War illnesses. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that the decision to extend the umbrella of Gulf War illness research will dilute the focus and erode the management of VA research.

While it is unclear whether veterans of the current Persian Gulf conflict should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the others. We believe that funding for research proposals categorized under Gulf War illnesses should be subject to a review by experts in this area to ensure precious research funding that is committed is properly managed, particularly with Congress's sustained interest in this issue depicted in the conference report of the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (Public Law 109-114), which directs VA to provide no less than $15 million to be used for Gulf War illness research and to evaluate establishing a research center of excellence devoted specifically to Gulf War illness.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled as a result of their military service in the Gulf War. The IBVSOs expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses that veterans of the Gulf War have experienced.

Unfortunately, veterans returning from all of our nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. Accordingly, the IBVSOs urge that Congress extend the provision of P.L. 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation periods" in which conditions associated with Gulf War service may manifest.

Many sick and disabled Gulf War veterans are frustrated over ineffective VA medical treatment and frequent denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. For example, VA uses clinical practice guidelines for chronic pain and fatigue; however, VA has not

yet developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a more traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines, as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War–related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support significant increases in the effort and funds devoted to such research by both federal government and private entities.

RECOMMENDATIONS:

Congress should ensure continued funding is provided for Gulf War veterans' illness research.

VA should continue to foster and maintain a close working relationship with the National Academy of Sciences in an effort to determine the toxins to which Gulf War veterans were exposed and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

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Lung Cancer Screening and Early Disease Management Pilot Program:

More than 50 percent of new lung cancer cases are diagnosed in former smokers, including many who had quit 20 or 30 years ago. Another 15 percent of new lung cancer cases occur in people who have never smoked, with possible causes including radon, asbestos, Agent Orange and other herbicides, beryllium, nuclear emissions, diesel fumes, and other toxins.

Over the next six years, one million Americans will die from lung cancer, most within months of diagnosis. It is the leading cause of cancer death, responsible for nearly 30 percent of all cancer mortality, more than breast, prostate, colon, liver, melanoma, and kidney cancers combined.

Since Congress passed the National Cancer Act in 1971, the five-year survival rates for breast, prostate, and colon cancers have risen to 88 percent, 99 percent, and 65 percent respectively, primarily because of major funding investments in research and early detection for those cancers. Lung cancer's five-year survival rate is still at 15 percent, reflective of the persistent underfunding of research and early detection. Lung cancer now kills three times as many men as prostate cancer and nearly twice as many women as breast cancer.

■ Impact on Military and Veteran populations

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarette packages in K-rations until 1976. The 1997 Harris report to the Department of Veterans Affairs (VA) documented the higher prevalence of smoking and exposure to carcinogenic materials among the military and estimated costs to VA and TRICARE in the billions of dollars per year. For example, the percentage of Vietnam veterans who ever smoked is more than 70 percent, double the civilian "ever smoked" rate of 35 percent. Asbestos in

submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are additional factors that have led to a 25 percent higher incidence and mortality rate for lung cancer among veteran populations.

A 2004 report by the Board on Health Promotion and Disease Prevention (HPDP) of the Institute of Medicine (IOM), "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer (2004)," concluded that the presumptive period for lung cancer is 50 years or more. Another report issued in 2005 by the HPDP, "The Gulf War and Health: Volume 3, Fuels, Combustion Products and Propellants (2005)," concluded that there is sufficient evidence for an association between battlefield combustion products and lung cancer.

Lung cancer is an indolent cancer that takes decades to develop, and in most cases no symptoms present until the cancer is already at late stage. Thus, while the disease may initiate under circumstances encountered during service under the DOD, the disease burden will fall most heavily on VA, and to a lesser extent on TRICARE. Because of the predominance of late stage diagnoses, more than 60 percent of lung cancer patients die within the first year, and late stage treatment is more than twice as costly as early stage.

■ Justification

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on CT screening of 31,500 asymptomatic people by a consortium of 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at stage 1 (versus 16 percent nationally) and the estimated 10-year survival rate for those treated promptly is 92 percent (versus a 15 percent 5-year survival rate nationally).

The benefits of this early detection and disease management protocol should be extended to veterans, especially those whose active duty service has placed them at higher risk for lung cancer.

■ Legislative History

Senate Report 108-087 on the Department of Defense Appropriations Bill, 2004 contains the following language:

"Lung Cancer Screening – The Committee urges the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to begin a multi-institutional lung cancer screening program with centralized imaging review incorporating state-of-the-art image processing and integration of computer assisted diagnostic tools."

Senate Report 109-286, Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2007 contains the following language:

"Lung Cancer Screening – The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on a proposal for this program."

■ Department of Energy (DOE) and Lung Cancer

Over the past eight years the DOE Office of Environment, Safety and Health has supported a medical screening program for DOE defense nuclear workers who were exposed to toxic and radioactive substances. The Worker Health Protection Program was originally authorized under Section 3162 of the 1993 Defense Authorization Act and has been funded through DOE appropriations. Currently more than 7,000 workers at seven different munitions plant sites are being screened free of charge annually for lung cancer. In FY 06, funding was increased to $14 million to cover an expansion of sites and the number of participants.

RECOMMENDATIONS:

VA should request and Congress should appropriate at least $3 million to conduct a pilot screening program for veterans at high risk of developing lung cancer.

VA should partner with the International Early Lung Cancer Action Program to provide early screening of veterans at risk.

Women Veterans:

The Department of Veterans Affairs (VA) must be prepared to meet the needs of the increasing numbers of women veterans seeking health-care services and ensure that its special disability programs are tailored to meet the unique health concerns of our newest generation of women veterans, especially those who have served in combat theaters.

In contrast to the overall declining veteran population in the United States, the female veteran population is increasing. According to VA, there are approximately 1.7 million women veterans comprising 7 percent of the total veteran population. VA estimates that by 2020 women veterans will comprise 10 percent of the veteran population.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. As of June 2006, there were nearly 400,000 women veterans enrolled in the veterans' health-care system. Women veterans comprise approximately 5 percent of all users of VA health-care services, and within the next decade, this figure is expected to double. The average female veteran is younger (estimated median age 46) than her male counterpart (estimated median age 60) and more likely to belong to a minority group. Additionally, according to the VA Women Veterans Health Program Office, as of August 31, 2006, approximately 70,000 women veterans served in military service in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) theaters of operations and have separated from service. Among the nearly 70,000 women having served in OEF/OIF, 37.2 percent, or 25,960, have received health care from VA since separation (up from 31.2 percent, or 13,693, approximately one year ago).

With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjusts programs and services as needed to meet its changing health-care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

The VA Veterans Health Administration (VHA) mandates that each facility, independent clinic, and community-based outpatient clinic (CBOC) ensures that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions, that is equal in quality to that provided to male veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is provided to women veterans, privacy issues and other deficiencies still exist at some facilities. VA needs to monitor and enforce, at the Veterans Integrated Service Network (VISN) and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. According to VA, 46 percent of VA facilities surveyed provide care to women through mixed gender primary care teams and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" noted that with the advent of primary care in VA, many women's clinics were dismantled and that women veterans were assigned to primary care teams on a rotating basis. Findings from the report indicate that this practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. Or, in cases where there are relatively low numbers of women being treated at a given facility, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health. Likewise, we agree that the health-care environment directly affects the quality of care provided to women veterans and has a significant impact on the patient's comfort, feeling of safety, and sense of welcome.

According to VA researchers, although women veterans report that they prefer receiving primary and gender-specific health care from the same provider or clinic, in actuality their care is fragmented, with different components of their care being provided by different clinicians with varying degrees of coordination. Additionally, researchers report there are a number of barriers to delivering high-quality health care to women veterans. Specifically, insufficient funding for women's health programs, competing local or network priorities, limited resources for outreach, inability to recruit specialists, small women veterans' caseloads at certain locations, limited availability of after-hours emergency women's health services, and an insufficient number of clinicians skilled in women's health. The findings of a 2006 study indicated that military sexual trauma quadruples the risk of homelessness among women veterans.

Researchers made several recommendations to address these barriers, including concentrating women's primary care delivery to designated providers with women's health expertise within primary care or women's health clinics; enhancing provider skills in women's health; providing telemedicine access to experts to aid in emergency women's health-care decision making; and increasing communication and coordination of care for women veterans using fee-based or contracted care services. We are pleased that funding has been approved for VA researchers to study the impact of the practice structure on the quality of care for women veterans and fragmentation of care for women veterans including unmet health-care needs for women with chronic physical and mental health conditions.

VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004, VHA's Office of Research and Development held a groundbreaking conference, "Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. In April 2005, a special solicitation was issued for research that will assess health-care needs of women veterans and demands on the VA health-care system in targeted areas, such as mental health and combat stress, military sexual trauma (MST), post-traumatic stress disorder (PTSD), homeless women veterans, and differences in era of service (e.g., Iraq versus Gulf War). An entire issue of the *Journal of General Internal Medicine* was dedicated to VA research and women's health in March 2006. Published findings include articles on the following topics: why women veterans choose VA health care; barriers to VA health care for women veterans; health status of women veterans; PTSD and increased use in certain VA medical care services; and PTSD and military sexual trauma.

The IBVSOs strongly encourage VA, as it takes steps to advance this agenda, to focus on research and programs that enhance VA's understanding of women veterans' health issues and ways to optimize health-care delivery and health outcomes for this patient population.

Equal access to quality mental health services is critical for women veterans, especially women veterans who have mental health conditions associated with serving in a combat theater or those who have suffered sexual trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, and the IBVSOs agree, that it is "essential that VA staff recognize the importance of the environment in which care

is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 19 percent of the women screened between fiscal years 2002 and 2006 responded "yes" to experiencing military sexual trauma, compared to 1 percent of men screened. In response to these reports, VA established a committee to explore ways to address the mental health needs of women veterans and to improve mental health services to women who have experienced MST. In 2006, VA developed an MST support team under its mental health service to specifically work with MST coordinators in the field to better monitor tracking, screening, treatment, and training programs for MST. We still encourage the VHA to implement earlier recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, and improved coordination with the Department of Defense (DOD) on transition of women veterans.

Given the increasing role of women in combat and with more than 70,000 women having served in OEF/OIF combat theaters, we are pleased that VA's Women's Health Science Division of the National Center for PTSD is evaluating the health impact of combat service on women veterans, including the dual burden of exposure to traumatic events in the war zone and military sexual trauma. According to the center, although there is no current empirical data to verify MST is occurring in Iraq, there have been numerous reports in the popular press citing cases of sexual misconduct and anecdotal reports to health care workers. In the center's Women's Stress Disorder Treatment Team, of 49 returning female veterans, 20 (41 percent) report MST.

The center notes that anecdotal reports from OEF/OIF veterans suggest a number of unique concerns that have a more direct impact on women than their male counterparts returning from combat theaters, including lack of privacy in living, sleeping, and shower areas; lack of gynecological health care; impact of women choosing to stop their menstrual cycle; gender-specific differences in urinating leading to health concerns for women, including dehydration and urinary tract infection. There are also reported findings that suggest distinct differences at homecoming, including that women may be less likely to have their military service recognized or appreciated; possible differential access to treatment services; and possible increased parenting and financial stress. Additionally, women may be more likely to seek help for psychological difficulties.

The center is looking at gender differences in mental health, military sexual trauma in the war zone, and gender differences in other stressors associated with OEF/OIF service and homecoming. A number of research initiatives/projects are focused on treatment of PTSD in women, enhancing sensitivity toward and knowledge of women veterans and their health-care needs among VA staff, and military sexual trauma among Reserve components of the armed forces.

The IBVSOs are pleased that VA is attempting to address the needs of women veterans returning from combat theaters in a variety of ways and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OEF/OIF women veterans in anticipation of gender-specific health issues. Additionally, we understand that VA intends to hold a special conference in early 2007 to better assess the unique needs of this newest generation of combat veterans. These women will have an opportunity to share their personal experiences and concerns so that VA programs and services can be improved and tailored to their specific physical and mental health care needs.

The Women Veterans Health Program Office and the local women veterans program managers (WVPMs) have partnered with the VA Seamless Transition Office to provide information at National Guard, Reserves, and family member demobilization briefings on VA services and programs for women veterans. VA should continue to strengthen its partnership with the DOD to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

WVPMs and benefits coordinators are another key component to addressing the specialized needs of women veterans. These program directors and benefits coordinators are instrumental in the development,

management, and coordination of women's health and benefits services at all VA facilities.

Given the importance of this position, the IBVSOs are concerned about the actual amount of time WVPMs are able to dedicate to women veterans' issues and whether they have appropriate administrative support to carry out their duties. According to VA, 71 percent of all WVPMs serve in a collateral role. Only 20 percent reported they were allocated more than 20 administrative hours per week to fulfill their program responsibilities during the fiscal year. With increasing numbers of women veterans, VA WVPMs must have appropriate support staff and adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to these veterans is especially important because they tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often, smaller programs, such as programs for women veterans, are left at risk of discontinuation. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to ensure priority is given to women veterans' programs so quality health care and specialized services are equally available to women veterans as to male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters, suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must address the health issues that pose special problems for women. The IBVSOs also recommend that VA focus its women's health research on finding the health-care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for a women's health research agenda.

RECOMMENDATIONS:

VA must ensure laws, regulations, and policies pertaining to the health care of women veterans are enforced at VISN and local levels.

VA must ensure that priority is given to women veterans' programs and determine which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized appropriate support staff and sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs for post-traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to women veterans as to male veterans.

VA should collaborate with the DOD to collect critical information about health and the health-care needs of women veterans to best identify strategic priorities for a women's health research agenda.

Ending Homelessness Among Veterans:

All veterans deserve access to comprehensive, high-quality, and affordable health care; an income at a level sufficient for obtaining and maintaining permanent housing, food, health care, and other basic human needs; and permanent, safe, high-quality, and affordable housing. No veteran should experience homelessness.

In testimony presented to Congress in 2006, a Department of Veterans Affairs (VA) representative reported that the number of homeless veterans on the streets of America on any given night had decreased by nearly 25 percent over the previous five years, from about 250,000 to 190,000.

VA reports homeless veterans are mostly males (97 percent), and the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance. About half of all homeless veterans have a mental illness, and more than two-thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders. VA reports the majority of women in homeless veteran programs have serious trauma histories, some life-threatening, and many of these women have been raped and have reported physical harassment while in the military.

According to VA, male veterans are 1.3 times as likely to become homeless as their nonveteran counterparts, and female veterans are 3.6 times as likely to become homeless as their nonveteran counterparts. Like their nonveteran counterparts, veterans are at high risk of homelessness because of having extremely low or no livable income, the extreme shortage of affordable housing, and a lack of access to health care.

Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder or have addictions acquired during or worsened by their military service. These conditions can interrupt their ability to keep a job, establish savings, and in some cases, maintain family harmony. Veterans' family, social, and professional networks may have been broken as a result of extensive mobility while in service or lengthy periods away from their hometowns and their civilian jobs. These problems are directly traceable to their experience in military service or to their return to civilian society without having had appropriate transitional supports.

While most Americans believe our nation's veterans are well-supported, in fact many go without the services they require and are eligible to receive. According to VA, 1.5 million veterans have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty. Neither VA nor its state and county departments are adequately funded to respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA reports its homeless treatment and community-based assistance network serves 100,000 veterans annually. Community-based organizations (CBOs) serve 150,000 annually. With an estimated 500,000 veterans experiencing homelessness at some time during a year—VA reaching only 25 percent and CBOs 30 percent of those in need—undoubtedly a substantial number of homeless veterans do not receive much-needed services. Likewise, other federal, state, and local public agencies—notably housing and health departments—are not adequately responding to the housing, health-care, and supportive services needs of veterans. Indeed, it appears veterans fail to register as a target group for these agencies.

Despite the decrease in the number of homeless veterans over the past five years, many veterans still need help. Additionally, this population may be experiencing significant changes. Homeless veterans receiving services today appear to be aging, and the percentage of women veterans seeking services is growing. Moreover, combat veterans of Operation Iraqi Freedom, Operation Enduring Freedom, and the global war on terrorism are returning home and suffering from war-related conditions that may put them at risk for homelessness.

These men and women are beginning to trickle into the nation's community-based homeless veterans service provider organizations and need help—from mental health programs to housing, employment training, and job placement assistance. With greater numbers of women in combat operations, along with increased

identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services are needed. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may also be contributing factors. In the next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans, women veterans, and combat veterans of America's current operations in Iraq and Afghanistan.

In addition to the recommendations listed below, Congress and the Administration should also consider findings and recommendations included in the 2006 annual report of the VA Advisory Committee on Homeless Veterans.

RECOMMENDATIONS:

Congress should increase appropriations for the VA Medical Services Account in order to strengthen the capacity of the VA Health Care for Homeless Veterans program to serve more homeless veterans; enable VA to increase its mental health and addiction services capacity; and enable VA to increase vision and dental care services to homeless veterans as required by law.

Congress must ensure homeless veterans' access to and utilization of mainstream health insurance and health services programs.

Congress should authorize and appropriate funds for competitive grants to community-based, faith-based, and public organizations to provide health and supportive services to homeless veterans placed in permanent housing.

Congress must develop a new source of funding for the health-care services needed to complement existing permanent housing and new permanent housing being developed for veterans experiencing long-term homelessness.

Congress should increase the authorization level of and appropriations for the Homeless Veterans Reintegration Program (HVRP). Funded by the U.S. Department of Labor (DOL), the HVRP is the only federal program wholly dedicated to providing employment assistance and competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program (VWIP). Funded by the DOL, the VWIP provides to states competitive grants geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

Congress should establish a Veterans Work Opportunity Tax Credit program. The program would provide an incentive for hiring homeless veterans by providing employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veteran.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to meet the demands for transitional housing assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans.

Congress should ensure that grantees under the Homeless Provider Grant and Per Diem program are reimbursed for services to homeless veterans at the same rate that VA reimburses states for domiciliary care services provided in state veterans' homes, without decrementing the GPD per diem rate based on other income streams.

Congress should increase appropriations for the therapeutic residence (TR) component of the Compensated Work Therapy (CWT) program, while ensuring that veterans receive the support they need. The CWT program helps veterans with disabilities to obtain competitive employment in the community and allows them to work in jobs they choose. The TR component provides transitional housing assistance to veterans with disabilities while they participate in the CWT program.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers.

Congress should improve coordination between VA-supported Community Homelessness Assessment, Local Education, and Networking Groups and HUD Continuum of Care programs.

Congress should enhance the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for HUD McKinney-Vento Homeless Assistance Act funds to develop specific plans for housing and services to homeless veterans. Organizations receiving HUD McKinney-Vento homeless assistance funds but not serving veterans should screen participants for military service and make referrals as appropriate to VA and homeless veterans service providers.

Congress should authorize and appropriate funds for a targeted permanent housing assistance program for low-income veterans.

Congress should hold federal agencies accountable for complying with statutory requirements pertaining to making available surplus, excess, underutilized, and unutilized federal properties, including VA capital assets, to nonprofit, profit, and public organizations for development of permanent and transitional housing units for veterans experiencing homelessness.

Congress should ensure that all service members separating from the armed forces are assessed to determine their risk of homelessness and are provided with life skills training to help them avoid homelessness.

Congress should ensure that, in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursement), VA facilities develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing and appropriate supportive services. Discharge planning protocols should include providing information about VA resources and assisting persons in applying for income security and health security benefits (such as supplemental security income, Social Security Disability Insurance, veterans disability compensation, and Medicaid) prior to release.

Congress should increase the authorization level of and appropriations for the Emergency Food and Shelter Program (EFSP) and add a homeless veterans service provider representative to the national and local EFSP boards. EFSP provides funds to community-based, faith-based, and public organizations to enable them to offer food, lodging, and mortgage, rental, or utility assistance to persons who are homeless or at risk of homelessness.

LONG-TERM-CARE ISSUES

Obviously, the Department of Veterans Affairs (VA) has examined the data, considered alternatives, and developed several options for meeting the surging demand for long-term-care services. The aging of the veteran population and its subsequent increasing need for long-term care has been well documented for more than a decade by the Government Accountability Office (GAO), *The Independent Budget (IB)*, and by VA itself. However, if VA has a strategic plan for providing long-term care, it is a well kept secret.

In the absence of a comprehensive strategic plan for long-term care, VA is forced to adapt existing programs, services, and budgets to meet current and future demand. It is also forced to experiment with new ideas within existing budgets to meet the increasing need for these services. Shifting workload from institutional programs to noninstitutional programs can only help for so long. Eventually, aging will take its toll and a wave of veterans who were able to remain at home, with appropriate noninstitutional services, will need institutional nursing home care. The aging of the veteran population and the growing number of young severely injured combat veterans will eventually strain VA's long-term-care capacity to a point at which quality will begin to falter.

The burning questions remain the same. How will veterans receive the care they have earned and deserve without a strategic plan for their care? How will VA receive the long-term-care resources it requires today and tomorrow without a long-term-care strategic plan? How will VA convince the Office of Management and Budget and Congress to fund the resources it needs to meet growing demand without a strategic plan? How well can VA care for America's elderly and young severely wounded combat veterans without a strategic plan?

■ Long-Term-Care Strategic Plan Mandated by Congress

In the waning days of the 109th Congress, the House of Representatives and the Senate bundled a broad array of veterans' issues and passed Public Law 109-461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006." Section 206 of the bill mandates the Secretary of Veterans Affairs to publish a strategic plan for the provision of long-term care within 180 days of the bill's enactment. VA's strategic plan must include cost and quality comparison analysis for all of VA's different levels of long-term care, detailed information about geographic distribution of services and gaps in care, and specific plans for working with Medicare, Medicaid, and private insurance companies to expand the availability of such care.

Additionally, Section 211 of the bill mandates VA to pay the cost of nursing home care provided by state veterans' homes to any veteran who has a service-connected disability rated 70 percent or more and is in need of such care and to any veteran for a service-connected condition that requires such care. The payment rate for this care will be governed by the prevailing rate in the geographic area.

The authors of *The Independent Budget* welcome this Congressional action, which requires VA to move forward in planning for the increasing needs of an aging veteran population. It is hoped that the 110th Congress will hold appropriate hearings to gather additional information from veterans about their long-term-care needs and desires.

■ The Aging of America's Veteran Population

VA has widely published data that describe an aging veteran population. VA's FY 2006–2011 Strategic Plan points out that the median age of all living veterans is 60 years. Other VA data say in the year 2000, approximately 10 million veterans were age 65 and older. Of that 10 million, approximately 5.4 million veterans were between 65 and 75 years of age, approximately 4 million were between 75 and 85, and approximately 540, 000 were 85 or older.

VA projections say that the veteran population age "85 or older" will increase by 110 percent between 2000 and 2020 and that this group of elderly veterans will peak in 2012 at 1.3 million, representing an increase of 143 percent over the total in 2000. VA's FY 2006–2011 Strategic Plan goes on to say that this large increase in the oldest segment of the veteran population has had, and will continue to have, significant ramifications on the demand for health-care services, particularly in the areas of long-term care.

Despite this VA data, VA's FY 2006–2011 Strategic Plan does not identify the needs of an aging veteran population as one of the Secretary's priorities. *VA's plan has no specific objectives or performance measures directly related to long-term care.* Regarding long-term care, Dr. Michael J. Kussman, Acting Under Secretary for Health says only, "The Veterans Health Administration (VHA) will expand its offerings of non-institutional alternatives to nursing home care and the capabilities of home-based care programs." Yet VA's 2006 Average Daily Census (ADC) data for noninstitutional care show a reduction in veterans served.

■ Disturbing VA Long-Term-Care Program Trend

Despite clear VA data that highlights the aging of the U.S. veteran population, VA's 2006 ADC data for its institutional care programs and its ADC data for its noninstitutional care programs show a reduction in the number of veterans served.

VA says little about the future direction of its nursing home care program, but VA is working to shift more of its long-term-care workload toward its noninstitutional care programs. For many veterans this is a positive policy, but for many other elderly veterans it is not. VA must be judicial in its decisions that guide veterans to home and community-based options for care. *The Independent Budget* authors are concerned that a constrained VA budget is forcing VA to downsize it nursing home capacity and turn to less expensive noninstitutional care in order to meet the growing demand for services. *VA must not substitute noninstitutional care for institutional (nursing home) care just because it is less expensive to do so in order to serve a greater number of veterans.*

■ VA Institutional Care

VA Nursing Home Expenditures/Venues of Care

VA's reported overall nursing home care expenditures in its three settings—VA-operated nursing homes, community nursing homes, and state veterans' nursing homes—increased from $2.3 billion in 2003 to nearly $3.2 billion in 2005 (GAO testimony 1/9/06). The percentage of patient workload provided in VA-operated nursing homes declined from 37 to 35 percent from 2003 to 2005. The percentage of workload in community nursing homes stayed about the same at 13 percent and the percentage of workload in state veterans' homes increased from 50 to 52 percent. (See table 1. LTC)

VA's Nursing Home Care Program

VA is a nationally recognized leader in providing quality nursing home care, but its ADC is being reduced each year. Congress has mandated that VA must maintain its nursing home ADC at the 1998 level of 13,391, but VA has not done so. VA's nursing home average daily census has continued to trend downward. VA has chosen to ignore the Congressional ADC mandate, and Congress has chosen to look the other way. Once again VA has failed to meet the Congressional ADC mandate.

Today, VA's long-term-care program focus is concentrated on expanding noninstitutional care programs. It seems that VA is hoping the financial stress of providing nursing home care will simply go away. However, demand for nursing home care will continue to increase because of expanding life expectancies. Plus, many elderly veterans who are safely utilizing noninstitutional

TABLE 1. LTC—NURSING HOME COMPARISON

(Dollars in Millions)

Nursing home setting	FY 2003	FY 2005	Change 2003–2005
VA-operated nursing homes	$ 1,697	$ 2,441	$ 743
Community nursing homes	$ 272	$ 352	$ 80
State veterans' nursing homes	$ 352	$ 382	$ 30
Total	**$ 2,321**	**$ 3,175**	**$ 853**

(NOTE: Data from GAO testimony 1/9/06.)

services today may not be able to tomorrow. VA must maintain a safe margin of nursing home beds that will meet the needs of America's oldest veterans and be capable of meeting the needs of other elderly veterans who can be expected to transition from VA noninstitutional care programs to nursing home care.

TABLE 2. LTC—AVERAGE DAILY CENSUS (ADC) VA'S NURSING HOME CARE PROGRAM

1998	13,391
2004	12,354
2005	11,548
2006	11,434
Increase/(Decrease)	(114)

(NOTE: ADC for 2006 is an unaudited number at this time.)

Special Program for Young Combat-Injured Veterans

VA must move forward in the development of institutional care programming for young Operation Iraqi Freedom and Operation Enduring Freedom veterans whose combat injuries are so severe that they are forced to depend on VA nursing home care. VA's current nursing home capacity is designed to serve elderly veterans, not young ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs.

Young veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident.

Culture Change

VA has made a positive step forward by embracing the philosophy of "culture change" in the operation of its nursing home care program. The culture change movement for nursing home care is centered around such core concepts as autonomy, privacy, dignity, flexibility, and individualized services. Culture change is a departure from the medical model for nursing home care. VA's challenge to implement culture change throughout its nursing home care program is to develop and implement guidelines for management practices that make it possible for nursing home staff to truly understand and act on the personal care needs and lifestyle preferences of residents.

The culture change movement supports new thinking. It changes an old philosophy that operates in a medical model of service delivery where the veteran is seen as a patient. Instead, the new model called "culture change" refers to veterans as residents and works to create an environment that preserves dignity and promotes self respect. Culture change creates a homelike atmosphere with sufficient space and access to personal living space. The resident is involved in care planning, has a say in room and roommate selection, develops his or her own daily routine, and makes menu choices.

VA's Community Nursing Home Care Program

VA has contracts with more than 2,500 private community nursing homes located across the country. In 2005, the ADC for VA's community nursing home (CNH) program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or basic ordering agreements. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

Veterans Health Administration Handbook 1143.2 provides instructions for initial and annual reviews of Community Nursing Homes and for ongoing monitoring and follow-up services for veterans placed in these facilities. The handbook updates new approaches to CNH oversight, first introduced in 2002, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

TABLE 3. LTC—ADC VA'S COMMUNITY NURSING HOME PROGRAM

2004	4,302
2005	4,254
2006	4,395
Increase/(Decrease)	141

(NOTE: ADC for 2006 is an unaudited number at this time.)

State Veterans' Homes

The state veterans' home program currently encompasses 130 nursing homes in 50 states and Puerto Rico. According to the GAO, half of VA's total nursing home workload in FY 2003 was provided in state veterans' homes. Dramatic reductions in the state veterans' home ADC were prevented when Congress refused to enact dramatic cuts to this program's budget as proposed by VA in its 2006 budget request. VA's projected ADC for state veterans' homes, under its proposed 2006 budget, would have fallen to 7,217 in 2006. VA now projects a state veterans' home ADC rate of 17,747 for 2006. VA's proposed 2006 long-term-care budget cuts would have decreased the state veterans' home ADC in 2006 by 10,530.

Fortunately, Congress realized the ramifications of VA's proposed 2006 long-term-care budget and its negative impact upon elderly veterans. VA's proposed 2006 long-term-care budget would have hurt veterans. The proposed 2006 VA budget also reflected little VA business acumen in light of GAO findings (GAO-05-65) that reported VA pays about one-third the cost of care in state veterans' nursing homes.

TABLE 4. LTC— ADC STATE VETERANS' HOMES

2004	17,328
2005	17,794
2006	17,747
Increase/(Decrease)	(47)

(NOTE: ADC for 2006 is an unaudited number at this time.)

In 2005 the ADC for state veterans' homes represented 52 percent of VA's total nursing home workload. Veterans are concerned about VA's desire and ability to meet increasing demand for nursing home care because of previous proposed cuts to the state veterans' home program and because of the downward VA nursing home average daily census spiral.

The GAO is similarly concerned about VA's nursing home program. In its November 2004 report (GAO-05-65) the GAO pointed out several problems that prevent VA from having a clear understanding of its programs effectiveness. The GAO recommended that VA collect and report data for community nursing homes and state veterans' nursing homes on the numbers of veterans that have long and short stays. GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. The GAO believed that this information would assist VA to conduct adequate monitoring and planning for its nursing home care program.

Congress has shown its concern about VA's long-term-care planning as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans' homes and to repeal nursing home capacity mandate under P.L. 106-117. Also, in July of 2005, Congress was asked to provide VA with an additional $1.997 billion for higher that expected health-care needs. Of this amount, $600 million was to be used to correct for the estimated cost of long-term care (VA press release July 14, 2005). Most recently, Congress has directed VA to develop a strategic plan for long-term care.

VA's lack of appropriate workload information gathering and data analysis has placed it in a weak position to do effective planning for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so. The Department of Veterans Affairs should be the advocate for veterans' long-term-care needs, not just the provider.

■ VA Noninstitutional Care

VA offers a spectrum of noninstitutional long-term-care services to veterans enrolled in its health-care system. In fiscal year 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home and community-based) budget and services. However, more needs to be done in this area. VA must take action to ensure that these programs, mandated by the P.L. 106-117, are available in each VA network. In May of 2003, the GAO (GAO 03-487) reported: "VA service gaps and facility restrictions limit veterans' access to VA non-institutional care." The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by the P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available.

The Independent Budget supports the expansion of VA's noninstitutional long-term-care services and also supports the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

TABLE 5. LTC— ADC FOR VA NONINSTITUTIONAL CARE PROGRAMS PREVIOUSLY REPORTED BY VA

	2004	2005	2006	Increase/ (Decrease)
Home-based Primary Care	9,825	11,594	12,641	1,047
Contract Skill Home Care	2,606	3,075	2,490	(585)
VA/Contract Adult Daycare	1,493	1,762	1,304	(458)
Homemaker Health Aid Services	5,580	6,584	5,867	(717)
Community Residential Care	5,771	6,810	3,692	(3,118)
Home Respite	84	99	118	19
Home Hospice	164	194	427	233
Total Noninstitutional Care Programs	**25,523**	**30,118**	**26,539**	**(3,579)**

(NOTE: ADC for 2006 is an unaudited number at this time.)

■ Future Directions

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meets veterans' needs and choices. VA can be expected to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the following:

- Continue "culture change" transformation to make nursing homes more homelike.
- Continued expansion of hospice and palliative care so VA can care for veterans and respect their choices for care at the end of life.
- Integration of young combat injured veterans into appropriately suited VA's long-term-care programs.
- Implementation, nationally, of a medical foster home program, that would provide veterans who can no longer safely reside in their own homes a homelike environment in their communities.
- Continued expansion of access to noninstitutional home and community-based care. VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances.
- Further collaboration between the Geriatrics and Extended Care programs and those of the Office of Care Coordination/Home Telehealth to provide services that are tailored to an individual veteran's needs.

■ VA's Care Coordination Program

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, post-traumatic stress disorder, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans' homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse or a social worker but other practitioners can provide the support necessary. There are also physicians who care-coordinate complex patients.

As veterans age and need treatment for chronic diseases VA's care coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and in some cases prevent or delay the need for institutional or long-term nursing home care.

As America's aging veteran population grows older and older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

■ VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination.

A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA cannot identify the exact locations of these veterans. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated long-term-care facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term-care services require specialized care from specifically trained professional long-term-care providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated long-term-care facilities for patients with spinal cord injury or disease, and none of these facilities are located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admittance. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA Capital Assets Realignment for Enhanced Services (CARES) initiative has called for the creation of additional long-term-care beds in four new locations (30 in Tampa, Florida; 20 in Cleveland, Ohio; 20 in Memphis, Tennessee; and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D long-term-care facility design and to develop a new SCI/D long-term-care staff training program. Additionally, VA is currently working with the Paralyzed Veterans of America to create an SCI/D long-term-care handbook that will identify the operational policies of SCI/D long-term care.

RECOMMENDATIONS:

VA must develop a strategic plan for long-term care that meets the current and future needs of America's veterans.

Congress must hold appropriate long-term-care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

Congress must provide the financial resources for VA to implement its long-term-care strategic plan.

VA must abide by P.L. 106-117's ADC capacity mandate for VA nursing home care and Congress must enforce its own requirement.

VA and Congress must continue to provide the construction/repair and per diem funding necessary to support state veterans' homes. Even though Congress has approved full long-term-care funding for eligibles in state veterans' homes under P.L. 106-117, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure.

VA must do a better job of tracking the quality of care provided in VA contract community nursing homes.

VA must increase its capacity for noninstitutional, home, and community-based care, including assisted living.

VA must ensure that each noninstitutional program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

Serious geographical gaps exist in specialized long-term-care services for veterans with spinal cord injury or spinal cord disease. As VA develops its strategic plan for long-term care, it must include provisions to provide specialized nursing home capacity throughout the entire country. VA must start by implementing the CARES SCI/D long-term-care recommendations.

VA must develop a mechanism to locate and identify veterans with SCI/D residing in non–SCI/D long-term-care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D.

VA must move forward in modifying its nursing home programs to meet the needs of younger combat-injured veterans.

ASSISTED LIVING

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, Secretary Principi forwarded a VA report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by the Mill Bill. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes Alaska, Washington, Oregon, and the western part of Idaho.

VA's ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon; Roseburg, Oregon; White City, Oregon; Spokane, Washington; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

VA's report on the overall assessment of the ALPP stated: *"The ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."*

Some of the main findings of the ALPP report include:

- *ALPP veterans showed very little change in health status over the 12 months post-enrollment.* As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- *The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.*
- *The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.*
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- *The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.*
- *ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment:* 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- *Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.*
- *Veterans were very satisfied with ALPP care.* The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- *Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).*
- *Case managers were very satisfied with ALPP.* Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

Secretary Principi's cover letter that conveyed the ALPP report to Congress stated that VA is not seeking authority to provide assisted living services, believing this is primarily a housing function. The authors of *The*

Independent Budget (IB) disagree and believe that housing is just one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

■ CARES and Assisted Living

Secretary Principi's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA.

The authors of *The Independent Budget* concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, the IB authors believe that any type of VA enhanced-use lease agreement for assisted living, or any other projects must be accompanied with the understanding that veterans have first priority for care or other use.

RECOMMENDATIONS:

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the authors of *The Independent Budget* believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's ALPP report seems most favorable and appears to be an unqualified success. However, *The Independent Budget* authors believe that to gain further understanding of how the ALPP program can benefit veterans, it should be replicated in at least three VISNs with a high percentage of elderly veterans.

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VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research:

Funding for Department of Veterans Affairs (VA) Medical and Prosthetic Research is inadequate to support the full range of programs needed to meet current and future health challenges facing veterans. Additionally, VA's aging research facilities are in urgent need of renovations and repairs.

VA medical care is touted as an industry leader—its dynamic transformation to this position validated by consistent scores higher than the private sector in patient satisfaction surveys, a cost efficiency with better health outcomes, and cutting-edge information technology. But this success could not have been realized without the premier research program that the VA administers. VA medical and prosthetic research is a national asset that attracts high-caliber clinicians to practice medicine and conduct research in VA healthcare facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

VA research is patient oriented, focusing entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three-quarters of VA researchers are clinicians that provide direct patient care to veterans. As a result, the Veterans Health Administration, as the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity.

For decades, VA has failed to request—and Congress has failed to mandate—construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor and major construction funding and researchers are often stymied by the lack of state-of-the-art facilities. Cutting-edge research demands cutting-edge facilities. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements until this backlog is addressed.

MEDICAL AND PROSTHETIC RESEARCH
(In Thousands)

FY 2007	$ 412,000
FY 2008 Administration Request	
FY 2008 *Independent Budget* Recommendation	$480,000

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Medical and Prosthetic Research Account:

Inadequate funding has jeopardized VA Research and Development's status as a national leader. Significant growth in the annual Research and Development appropriation is necessary to continue to achieve breakthroughs in health care for its current population and to develop new solutions for its most recent veterans.

The Department of Veterans Affairs (VA) strives for improvements in treatments for conditions long prevalent among veterans such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by veterans of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), such as extensive burns, multiple amputations, compression injuries, and mental stress disorders. These returning OEF/OIF veterans have high expectations for returning to their active lifestyles and combat. The seamless mental and physical reintegration of these soldiers is a high priority, but still a difficult challenge that the VA Research program can address.

Despite high productivity and success, funding for VA medical and prosthetic research has not kept pace with other federal research programs or with funding for VA medical care. The VA research program has done an extraordinary job leveraging its modest $412 million appropriation into a $1.7 billion research enterprise that hosts multiple Nobel laureates and produces an exceedingly competitive number of scientific papers annually. VA research awards are currently capped at $125,000, significantly lower than comparable federal research programs. However, VA investigators would be unable to compete for additional funding from other federal sources without the initial awards from the Medical and Prosthetic Research Account.

VA has a distinctive opportunity to recreate its health-care system and provide progressive and cutting-edge care for veterans through genomic medicine. As the largest integrated health-care system in the world with an advanced and industry-leading electronic health record system and a dedicated population for sustained research, ethical review, and standard processing, VA is the obvious choice to lead advances in genomic medicine. Innovations in genomic medicine will allow VA:

- to reduce drug trial failure by identifying genetic disqualifiers and allowing treatment of eligible populations;
- to track genetic susceptibility for disease and develop preventative measures;

- to predict response to medication; and
- to modify drugs and treatment to match an individual's unique genetic structure.

Additional increases are necessary for continued support of new initiatives in neurotraumas, including head and cervical spine injuries; wound and pressure sore care; pre- and post-deployment health issues with a particular focus on post-traumatic stress disorder; and the development of improved prosthetics and strategies for rehabilitation from polytraumatic injuries.

The projected biomedical research and development inflation index (BRDPI) for FY 2007 is 3.4 percent, which necessitates a $14.008 million increase over FY 2007 funding. To ensure that VA Research continues to attract high-caliber investigators, annual award amounts must be reevaluated and adequately increased to compete with other federal research programs. The IBVSOs recommend a phased increase to accommodate the significant costs associated with updating this cap. In FY 2008, Congressional direction to increase the award limit accompanied by adequate funding so as not to reduce awards will demonstrate our nation's commitment to researchers working to help veterans.

The new VA genomic medicine project represents a monumental advancement in the future of the VA Medical and Prosthetic Research program and in the future of America's health-care system. This endeavor will require sustained increases for VA research funding in the coming years. A VA pilot program involving 20,000 individuals and 30,000 specimens provides estimates that approximately $1,000 will be necessary for each specimen. The estimated costs for VA's genomic pilot program and support for current research endeavors complete the additional funding request of *The Independent Budget* recommendations.

RECOMMENDATION:

The Independent Budget veterans service organizations (IBVSOs) recommend an FY 2008 appropriation of at least $480 million. This appropriation offsets the higher costs of established research resulting from biomedical inflation and wage increases.

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Research Facilities Consistent with Scientific Opportunity:

Many Department of Veterans Affairs (VA) research facilities are outdated and in need of repair or renovation.

In May 2004, Secretary of Veterans Affairs Anthony J. Principi approved the Capital Asset Realignment for Enhanced Services (CARES) Commission report that called for implementation of the VA Under Secretary of Health's Draft National CARES Plan for VA research. This plan recommended $87 million to renovate existing research space.

In House Report 109-95 providing appropriations for FY 2006, Congress expressed concern that "equipment and facilities to support the research program maybe be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." It noted, "more resources may be required to ensure that research facilities are properly maintained to support the Department's research mission." To assess VA's research facility needs, Congress directed VA to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, along with suggestions for correction.

In anticipation of the completion of this report, the House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs proposed $12 million dedicated to renovating and upgrading VA medical research facilities within the Minor Construction budget. *The Independent Budget* veterans service organizations believe Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both

immediate and long-term needs. Congress should also use the VA report as the basis for prioritizing allocation of such funding to ensure that the most urgent needs are addressed first. For these purposes, *The Independent Budget* recommends $45 million.

RECOMMENDATIONS:

Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both immediate and long-term needs. Congress should also use the VA report as the basis for prioritizing allocation of $45 million to ensure that the most urgent needs are addressed first.

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Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis.

■ Nursing Workforce

The Veterans Health Administration (VHA) has the largest nursing workforce in the country with nearly 61,000 employees in nursing, including registered nurses (RNs), licensed practical nurses (LPNs), and other nursing personnel. Maintaining a strong nursing workforce is essential to providing high-quality health care to our nation's sick and disabled veterans. Unfortunately, the country at large is continuing to experience a shortage of nursing personnel. Likewise, VHA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also can cause diversions of veterans to private sector facilities at great cost. This situation is complicated by the fact that the Department of Veterans Affairs (VA) has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier hospital stays, and requires more skilled nursing care.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation grows more critical each fiscal year. Inadequate funding has resulted in sporadic hiring freezes across the country. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties due to shortages of ward secretaries and other key support personnel. These staffing deficiencies impact both patient programs and VA's ability to retain an adequate nursing workforce.

National Commission on VA Nursing

VHA's Succession Strategic Plan for Fiscal Year (FY) 2006–2010 states, "VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs. These challenges include continuing to compete for talent as the national economy changes over time and recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who receive retirement eligibility each year."

Like other health-care employers, VHA must actively address those factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. In addition, it is essential adequate funds are appropriated for recruitment and retention programs for the nursing workforce.

In 2002, the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and address the future of the nursing profession within the Department of Veterans Affairs (VA). The commission developed the desired future state for VHA nursing and recommendations to achieve that vision.

The executive summary of the commission report states:

> Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses comprise the largest proportion of healthcare providers in the Department of Veterans Affairs. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

Simultaneously, the Office of Nursing Service developed a strategic plan to guide national efforts to advance nursing practice within VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals. These goals encompass and address many of the recommendations of the VA Nursing Commission, as well as the findings in current literature.

1. **Leadership Development:** This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the High Performance Development Model for all levels of nursing personnel. This goal also addresses issues related to the nursing Professional Qualification Standards and the Nurse Professional Standards Board as discussed in the commission report.

2. **Technology and System Design:** This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.

3. **Care Coordination and Patient Self-Management:** This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality, reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

4. **Workforce Development:** This goal focuses on improving the recognition of and opportunities for the VA nursing workforce. Areas of emphasis are as follows:

   - utilization: to maximize the effective use of the available workforce;
   - retention: to retain a qualified and highly skilled nursing workforce;
   - recruitment: to recruit a highly qualified and diverse nursing staff into the VHA; and
   - outreach: to improve the image of nursing and promote nursing as a career choice through increased collaboration with external partners.

This goal also includes an emphasis on the importance of striving for the values exhibited by the philosophy of the Magnet Recognition Program of the American Nurses Credentialing Center. The commission report addresses all of these areas as critical to the future of VA nursing.

5. **Collaboration:** This goal focuses on forging relationships with professional partners within VA, across the federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.

6. **Evidence-Based Nursing Practice:** This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing-sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

The VHA, in its assessment of current and future workforce needs, identifies RNs as the number one priority in recruitment, with LPNs and nursing assistants also among the top 10 occupations with critical recruitment needs. Recommendations from this workforce assessment include implementing the commission's recommendations, enhanced new employee induction programs, and supervisory training. Additionally, the plan recommends continuing support of employee education programs, implementation of new initiatives for student (including high school outreach) recruitment, and improving the retention of trainees as permanent employees. Finally, the VHA recommends the continuing need to maintain a national recruitment program with innovative approaches and effective outcomes.

The Independent Budget veterans service organizations support the commission's recommendations, the VA's Office of Nursing Service's strategic plan, and the *VHA Workforce Succession Strategic Plan FY 2006–2010 (October 2005)*. We strongly urge Congress to develop a budget for VA health care that will allow the VHA to invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles. The commission's legislative and organizational recommendations are a blueprint for the reinvention of VA nursing. The VA model will serve as a foundation for the creation of a care delivery system that meets the needs of our nation's sick and disabled veterans and those providing their care.

In an attempt to address issues impacting registered nurses in the workplace, the Nurses Organization of Veterans Affairs (NOVA), a professional organization of more than 35,000 RNs employed by VA, conducts a biennial survey of its membership. The 2005 membership survey identified an adequate budget for the VHA as the legislative issue most important to NOVA members, followed by patient safety, locality pay, and the nursing shortage.

Members identified their greatest challenges as computerized charting and adequate computers. Respondents noted that problems with bar code medication administration equipment can lead to frustration with this technology, although it has reduced medication errors. NOVA nurses identified salaries competitive with the private sector as having the highest impact on recruitment, followed by flexible work schedules and adequate staffing. Because many VA nurses are eligible to retire now, or will become eligible in the next five years, the top enticement to stay in VHA nursing was flexible working hours. Only 37.5 percent of NOVA members believed VHA nursing salaries to be competitive with the private sector, and even fewer, 20.4 percent, indicated their facility would meet the criteria for Magnet Hospital designation. Last, the survey included several questions about the legislative process. Educating legislators was identified as important for improving the image of VA nursing.

RECOMMENDATIONS:

VA should establish recruitment programs that enable the VHA to remain competitive with private sector marketing strategies.

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

ADMINISTRATIVE ISSUES

Volunteer Programs:

The Veterans Health Administration (VHA) volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 677.7 million hours of volunteer service to America's veterans in the Department of Veterans Affairs (VA) health-care facilities. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee composed of 60 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2006, VAVS volunteers contributed a total of 12,411,687 hours to VA health-care facilities. This represents 5,967 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $234.8 million if VA had to staff these volunteer positions with FTEEs.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated to be $50.4 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers is increasing dramatically as additional demands are being placed on VA staff. Health care is changing, which means there is opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that the VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 381,000 hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

RECOMMENDATION:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

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Contract Care Coordination:

The Department of Veterans Affairs (VA) should ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private, community-based providers at VA expense.

Current law authorizes VA to contract for non-VA health care (on a fee or contract basis) and scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) agree that contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans who are enrolled in VA care. We have consistently opposed proposals seeking to contract for health care provided by non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and quantity of VA services for new as well as existing veteran patients.

Currently VA spends approximately $2 billion each year on purchased care outside the walls of VA. Unfortunately, VA is not able to track this care, its related costs, outcomes, or veteran satisfaction levels, and VA has no consistent process for veterans receiving contracted-care services to ensure that:

- effective care is delivered by certified, fully licensed or credentialed providers;
- continuity of care is properly monitored by VA and that patients are directed back to the VA health-care system for follow-up when necessary;
- veterans' medical records are properly updated with contract provider and pharmaceutical information; and
- the process is part of a seamless continuum of services to facilitate improved health status and veterans' access to necessary care.

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that includes integrated clinical, record, and claims information for veterans referred to community-based providers at VA expense. Preferred pricing allows VA medical facilities to save money when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider network (PPO) providers so that VA could:

- receive a discounted rate for the services rendered;
- use a mechanism to refer patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs), when a veteran inadvertently uses a PPO provider, not all facilities have taken advantage of the cost savings that are available to them. Therefore, in many cases, VA has paid more for contracted medical care than is required. We are pleased that, in response to this realization, the VA made participation in the Preferred Pricing Program mandatory for all VAMCs beginning in October 2005. As a result of mandatory facility participation, VA will likely yield $34.9 million in savings for fiscal year 2007. Despite the significant overall savings achieved through this program (more than $65 million to date), there are several major changes that can be made to improve the access, quality, and cost of contracted VA care.

The Preferred Pricing Program is the foundation upon which a more proactive managed care program should be established that will not only save significantly more money in the purchased care programs, but, more important, will provide VHA a mechanism to fully integrate veterans' community-provided medical care into the VHA health-care system. By partnering with an experienced managed-care contractor, VA can define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program should include the following:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor should require providers to meet specific requirements, such as the timely communication of clinical information to VA, proper and timely submission of electronic claims, meeting VA established access standards, and complying with director's performance standards.

- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor addresses both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system.

- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.

- Optimized workload for VA facilities and affiliates while costs for non-VA care are better controlled.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves its health-care and financial objectives. Doing so will improve patient care quality, optimize the use of VA's increasingly limited resources, and prevent overpayment when utilizing community contracted care.

Current law allows VA to contract for non-VA health-care (on a fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. The IBVSOs support a limited VA contract care coordination effort that includes integrated clinical and claims information for veterans referred to community-based providers at VA expense.

However, VA contracted care should be used judiciously in the specific circumstances mentioned so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans. The IBVSOs have consistently opposed proposals seeking to contract out health care provided by non-VA providers on a broad basis. Such proposals, ostensibly seeking to expand VA health-care services into broader areas serving additional veteran populations, in the end only dilute the quality and quantity of VA services for new as well as existing veterans.

Approximately one year ago VA announced "Project HERO," and indicated its goal to be consonant with the ideas expressed by the IBVSOs in improving VA contract care coordination. On closer examination, we concluded this initiative to be ill-considered and potentially dangerous to the continued integrity and availability of specialized health-care services within the VA system. Accordingly we opposed that project, and it was withdrawn. Recent information provided by VA on a new initiative to improve contracting for veterans' care outside VA facilities seems pointed in a direction consistent with our views on this topic. We look forward to further developments in this initiative and will support it to the extent it remains consistent with our goals while neither expanding the gross level of contract care nor eroding the quality of health-care services available within VA facilities for sick and disabled veterans.

RECOMMENDATIONS:

VA should establish a phased-in, contracted care coordination program that incorporates the preferred pricing program discussed above and is based on principles of sound medical management.

Veterans who receive care outside VA, at VA expense and authorization, should be required to participate in the care coordination model. This program should be tailored to VA and veterans' specific needs.

Contract care should be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care, are geographically inaccessible to the veteran, and in certain emergency situations, and should be managed so as

not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans.

VA should engage an experienced contractor willing to go "at risk" to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor should jointly develop identifiable measures to assess program results and share these results with stakeholders, including the IBVSOs. Care should be taken to ensure inclusion of important affiliates in this program.

The components of a care coordination program should include claims processing, medical records management, and centralized appointment scheduling. VA should also implement a call center or advice line for veterans who are referred outside the VA health-care system for consultations and specialized care.

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Federal Supply Schedule for Pharmaceuticals:

The Department of Veterans Affairs (VA) must maintain and protect the ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P).

A number of states and the District of Columbia have recently considered legislation that would tie Medicaid drug prices to the discounted prices now contained in the FSS-P. Passage of any legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing because vendor contracts contain a clause allowing their cancellation in this event. Legislation considered during recent sessions of Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P and VA drug discounts by referencing these reduced prices as a target for obtaining Part D drugs, is of even greater concern.

Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL 101-508), has demonstrated that if these types of legislative initiatives are enacted, VA's pharmaceutical discounts could be diluted and costs increased, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases, on behalf of itself and other federal entities through contracts with responsible vendors, approximately 24,000 pharmaceutical products annually. These purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. Since VA's pharmaceutical purchases are now roughly $4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

RECOMMENDATION:

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the FSS-P.

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Fee-Basis Care:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for fee-basis care continue to erode the effectiveness of this necessary health-care benefit.

Fee-basis care allows eligible service-connected veterans who live in areas that are geographically inaccessible to Department of Veterans Affairs (VA) medical facilities or who need specific services unavailable at VA to use private sector clinicians at VA expense. Additionally, veterans authorized for fee-basis care generally are required to choose their own medical providers.

Veterans who are approved by VA to utilize fee-basis care are sometimes unable to secure treatment from a community provider because of VA's regulated level of payment for medical services. We are especially concerned that service-connected disabled veterans who are authorized to use fee-basis care are at times required by the only provider in their community to pay for the care up-front. In these instances, veterans must pay for the medical care they need and then seek reimbursement from VA. Furthermore, because VA pays at the Medicare rate or will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, veterans who must pay for their care up front and then seek reimbursement from VA end up paying for part of their care.

We applaud VA for addressing existing variability in processing a fee-basis claim, which affects the timeliness to pay a claim, by initiating improvements to its business practice. While software improvements to increase program efficiency and regulatory changes to improve program effectiveness have been delayed, we believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives.

RECOMMENDATIONS:

When VA preauthorizes fee-basis care for a veteran, VA should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out of pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for care veterans receive in the community.

With support from VA leadership, a standard business practice for efficient and timely processing of claims for fee-based care should be established.

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VA Physician and Dentist Pay Reform:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that Department of Veterans Affairs (VA) clinical professional and labor stakeholders were not consulted or permitted to be involved in establishing their new pay system and that the new system may not have achieved its purposes as an effective tool for recruitment and retention.***

In 2004, Congress passed the Department of Veterans Affairs Personnel Enhancement Act, Public Law 108-445. This new law reformed the pay and performance system used by VA in employment of its physicians and dentists. In 2003, in a legislative hearing before the House Committee on Veterans' Affairs, VA testified that the system was "in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future." This legislative proposal was the VA health-care system's top legislative goal for the 108th Congress. Enactment of this proposal was supported by the major veterans organizations, including the

IBVSOs, who expressed their support for VA to be given new pay authority to attract and retain the best physicians and dentists for the care of sick and disabled veterans into the future.

VA worked for more than one year to implement this significant new legislation, whose rules became effective in January 2006. This act is the most significant reform of a pay system for VA employees since the enactment of the Civil Service Reform Act in 1978, and it represents the first real change in physician pay since 1991.

Congress stated its intention for VA to work closely in conjunction with stakeholders in fashioning the new pay system. Senate Report 108-357, supporting the purposes of the act, stated: "Finally, the Committee bill requires that practicing physicians have a significant role in making recommendations to the Secretary or his or her designee as to the appropriate levels of salaries paid to members of their professions. Physicians and dentists are at the front-lines of medicine; they know what is needed to provide care for veterans. This provision advances the tradition of cooperation among labor and management in the Federal sector, particularly within the healthcare environment."

The IBVSOs remain concerned about whether VA met clear Congressional intent in that regard. Stakeholders from the VA medical, dental, and labor sectors have reported that they have not been consulted or involved in establishing the new pay system, which was completed in the summer of 2006 and established new compensation rates for 14,000 VA physicians and 700 VA dentists and oral surgeons. We have been informed that essentially none of those required consultations occurred, that some pay tiers and bands were set arbitrarily, that proposed pay reductions in some disciplines were made in direct contravention of the intent of Congress, and that a number of deserving specialties essentially received no pay adjustment as a result of implementation.

We urge VA to engage labor and professional associations that remain concerned about the new pay and performance system to ensure it gains their continuing cooperation as VA manages this new pay policy. As indicated in the Senate legislative report, VA physicians and dentists are essential caregivers, educators, and researchers in the VA health-care system. This act was intended for their benefit, to attract them to VA careers and to sustain them in providing outstanding care to veterans. We would hope these purposes would have been transparent and that VA would want to involve representatives of professions in establishing and managing their pay system. We urge VA to do so and also to examine whether additional deserving physician and dentist groups should receive additional pay in accordance with this new authority.

RECOMMENDATIONS:

The IBVSOs urge VA to actively engage labor and professional associations that remain concerned about the new pay and performance system, to ensure it gains their cooperation as VA manages and refines this approach to pay the current clinician workforce. We also urge the Secretary and Under Secretary for Health to review this program to ensure its overriding goal was in fact met—to relieve the "critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future."

Should the Secretary discover that the new pay system lacks essential elements to enable VA to meet its recruitment and retention goals, we recommend the Secretary propose legislation to Congress, or take regulatory action, to remedy this problem.

Challenges in VA Information Technology:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned about the Secretary's decision to centralize all information technology (IT) in the Department of Veterans Affairs (VA) because of a likely deleterious impact on health-care quality.***

In *The Independent Budget for Fiscal Year 2007*, the IBVSOs expressed concern about the status of IT in VA. For years, some of VA's approaches, budgets, policies and initiatives in information technology have been controversial, wasteful, and, ultimately, unworkable. Many fell into disuse and were cancelled (i.e., "HRLinks"). One memorable initiative, "CoreFLS," collapsed amidst its trial implementation in 2003. Over a period of years, Congressional committees applied increasing pressure on VA officials to affix accountability for IT failures and waste. These efforts included demands to centralize IT budget and authority in one chief information officer (CIO) who would report to the Secretary; to apply more acute, detailed and timely reporting requirements; and, in general to provide more acute scrutiny in VA IT practices, initiatives, policies, and expenditures. The CoreFLS catastrophe triggered a number of investigations and resulted in the resignation of several officials, a shakeup of assignments, and cancellation of contracts. The CoreFLS incident brought new energy to the calls for VA IT reform.

In 2006, VA experienced a unique and disastrous event when in May it was discovered that a single laptop computer in the personal residence of a VA data analyst, which contained personal and sensitive information on the entire American veteran population and all currently serving military active duty personnel, was stolen. Although the computer and its data were subsequently recovered, and while the FBI made a determination that the sensitive data in this recovered computer had not been breached by the thieves, this incident generated new concerns about the security of personal information, not only in VA but across the federal government and large private businesses. Several committees of Congress demanded improvements in data security and data management on a large scale to prevent a recurrence in any federal department or agency of such an outrageous breach of personal information held by the government.

Soon after the theft, the former Chairman of the House Committee on Veterans' Affairs introduced legislation that would centralize information control, flow, security, planning, programming, budgeting, and resources, to a new "Under Secretary for Information Security," an official who would serve as a peer to the two existing VA Under Secretaries (for Health and Benefits). This bill, similar to a bill introduced in 2005 based on prior IT conditions in VA, quickly passed the House unanimously but generated no companion bill in the Senate.

The House and Senate Veterans' Committees approved legislation at the end of the 109th Congress that enacts some of the security and notification provisions in the latest IT bill, but the IBVSOs believe it is important to note that Congress did not agree to statutorily mandate centralization of the management of all IT in VA. Nevertheless, the VA Secretary announced late in 2006 his intention to carry forward his earlier decision to centralize the IT security function by adding to it the IT development function as an additional centrally controlled activity. Thus, as this *Independent Budget* is being presented, IT functions, resources, and personnel are being collected across the three VA administrations and numerous staff offices and are now being consolidated under one official in VA central office, the Assistant Secretary for Information Management—in effect, VA's "chief information officer." Despite the outrage expressed by many veterans service organizations over the theft of veterans' personal data, the IBVSOs remain concerned that centralizing all vital IT functions presents new challenges and may result in unfortunate consequences.

The IBVSOs acknowledge that a number of problems have plagued VA's IT programs and that better means need to be employed to keep VA from wasting resources on frivolous ideas or applications or investing in large-scale initiatives that are unsupported by the field staffs who ultimately must implement them (such as in the HRLinks and CoreFLS failures). We certainly agree that IT security, especially that involving personally identifiable records of veterans, must be paramount in VA's actions. We deplore the theft of VA computers containing sensitive data. Nevertheless, the IBVSOs are convinced that whatever course is taken to reform IT at the departmental "enterprise" level, the Veterans Health Administration's seminal accomplishments that established the world's foremost computerized patient care records system should not be compromised at the expense of central control.

The VA health-care system has been developing a unique VA computerized patient care record system for more than 30 years. The most important and lasting value of the VHA's automated system is that it was conceived and developed by VA clinical, research, and informatics specialists—those who actually deliver VA health care every day in VA facilities. The current version of this system, based on the VHA's self-developed VistA software, sets the standard for electronic medical records in the United States and has been publicly praised by the President as a model for all health-care providers. In fact, VistA, available free of charge in the public domain, is being imported into a number of U.S. and foreign health-care systems. Recently the government of West Virginia contracted with a private company to install VistA in all public hospitals in that state.

The existence of computerized patient care records enables the VHA to provide better and more efficient health care, and VistA empowers VA, uniquely, to avoid medical mistakes that are routinely made by other providers in the private and public sectors. Given that the Institute of Medicine estimates that avoidable medical mistakes cost 90,000 lives annually, it is no exaggeration to say VistA saves veterans' lives.

The VHA's health-care quality improvements over the past decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on the Accreditation of Healthcare Organizations, the National Quality Forum and the Agency for Health Care Quality, and Research of the Department of Health and Human Services. For the first time in history, mainstream media and press are reporting VA health care's high quality as news. Reports in 2006 in such publications as *Business Week and Time Magazine* have clearly documented VA's rise in quality and efficiency, in no small measure because of the advent and universal employment of VistA in VA patient care. While the IT accomplishments alone certainly did not improve VA health care, the integration of IT with VA's enrollment, laboratory, radiology, pharmacy, scheduling, personnel, logistics, management, and reporting systems has uniquely enabled VA to deliver and coordinate care as never before—and to do so at a level well beyond existing capabilities of other public and private providers. We believe the VHA's IT system is inseparable from its clinical care system.

Given the degree of success evident in the VHA, the authors of *The Independent Budget* cannot find justification for centralizing VHA IT to a non-VHA environment. One reason VHA IT has been so successful is that the Under Secretary controls and manages the IT programming and budget for the VHA, while thousands of clinical and other personnel involved in delivering direct health care also serve as software developers, subject matter experts on technical evaluation panels, and thus substantive advisors, to achieve an IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage. Without IT integration to this degree, we contend that the VHA would never have been able to double patient enrollment since 1995, nor to significantly reduce the cost of care, while improving quality.

The IBVSOs do not believe a VA "data czar" can manage VHA IT with the same degree of success or with the same sensitivities that the VHA has achieved with its current approach. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a web-enabled system already well into its developmental and planning phase, overseen by VHA clinicians. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these dollar savings in the case of the VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of new bureaucracy from centralization. Removing field facility personnel, especially clinical caregivers and management personnel, from the planning and development of clinical IT could doom future developments to mediocrity and ultimate decline. We understand that the current acting Under Secretary for Health has been assigned to lead a task group in examining how to balance VHA's special clinical interests in IT versus the Secretary's decision to centralize management, development, budget, and administration of IT systemwide. We are anxious to learn how the VHA will be able to sustain its excellence in IT development in the bureaucratic environment of Washington, DC.

Dr. Jonathan C. Javitt, former IT advisor to President Bush, testified as follows at a Congressional hearing on September 28, 2005:

> The centralization of VHA's electronic health records program is likely to have a disastrous effect on the continued success of

> that program; which President Bush identified as the only place IT has really shown up in health care, a terrible effect on the morale of VA care providers; and on the system's productivity. Worst, it will damage the health of our nation's Veterans to whom we owe so much.

The IBVSOs believe Dr. Javitt's analysis is still as correct as when he stated it.

Motivated by the computer theft, the Secretary has decided to restructure IT to give a departmental CIO more authority. The Secretary retains authority to empower the current CIO with additional responsibility, including some of the ideas embedded in the arguments that would centralize IT completely. The current CIO exercises authority delegated by the Secretary and mandated by the Chief Information Officer Act codified in Title 40, United States Code. Nevertheless, VHA's relative IT independence from strong central control is a success story. We believe this unique progress should be sustained by enabling the VHA, with the Under Secretary for Health in the lead, to retain its current authority in IT planning, development, programming, operations, and budgeting for computerized patient care records systems.

The IBVSOs are concerned that total centralization would retard the creative elements that so characterize VHA's current IT environment and its future viability. VA clinicians have high motives toward investigation, research, and teaching. VHA's IT environment feeds innovation and creative applications to solve difficult and complex problems in clinical care, particularly in the university-affiliated environment. How long will such an environment be sustained if major development decisions on VHA IT are being made in Washington and managed through a centralized bureaucracy? We believe such potentially opposing forces will be difficult to reconcile.

In summary, the IBVSOs remain highly skeptical of total centralization of IT in VA, particularly for its likely deleterious impacts on the VHA, VistA and HealtheVet, and on veterans served by the VHA. We are concerned that centralization may rupture the strong, vital link that has been established between quality of VA health care and VHA IT programs supporting that quality.

RECOMMENDATIONS:

Given the recent Congressional decision to improve IT security and accountability but to decline to statutorily centralize all control over IT, VA should proceed with great caution in centralizing all aspects of information technology.

To ensure VA remains in the forefront of quality health-care providers, the VHA should be provided the means to continue investing in and refining VistA, while developing the next generation of clinical information technologies that will aid health-care delivery to the nation's veterans.

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Veterans Affairs Physician Assistant:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time employee equivalent (FTEE).

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,574 PA FTEE positions. Since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VA has continued to assign this duty as a part-time field employee, as collateral administrative duties in addition to their clinical duties. *The Independent Budget* has requested for five years that this position be a FTEE within the Veterans Health Administration. In addition, in Senate Appropriations language in 2002 and again in 2003, it was requested and ignored.

The VA Under Secretary for Health has consistently refused to establish this important FTEE, and despite numerous requests from members of Congress, the veterans service organizations, and professional PA associations, VA has maintained this position as part-time, field-based with a very limited travel budget. This important occupation's representative has not been appointed to any of the major health-care VA strategic planning committees, has been ignored in the entire planning on seamless transition, and was not utilized during the emergency disaster planning and VA response to Hurricane Katrina.

PAs in the VA health-care system were the providers for approximately 8.7 million veteran visits in FY 2004; and PAs work in primary care, ambulatory care clinics, emergency medicine, and in 22 other medical and surgical specialties. PAs are a vital part of VA health-care delivery, and *The Independent Budget* supports the inclusion of a PA advisor in VA headquarters' Patient Care Services, FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to enact and fund this FTEE within the budget for FY 2008 and to ensure the position is in Washington, DC.

The Independent Budget veterans service organizations fully support Congress legislatively correcting this long-standing problem.

RECOMMENDATION:

Congress should legislatively mandate the Veterans Affairs physician assistant advisor to the Under Secretary for Health as a FTEE within VA, allowing the PA consultant to become fully integrated into VHA policy management and health-care planning.

Construction Programs

The Department of Veterans Affairs (VA) construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a systemwide, data-driven assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation, but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, *The Independent Budget* veterans service organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

■ CARES Timeline

- 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
- 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
- 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
- 2004—February: VA Secretary receives CARES Commission recommendations.
- 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES website, www.va.gov/cares. As of December 2006, only 10 of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES decision document and its established priorities, or with the findings of the CARES review commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past *Independent Budgets* we warned against this, pointing out that there were a number of legitimate construction needs identified by local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note that in its final hours in December 2006, the 109th Congress enacted Public Law 109-461, an act that included authorizations for fiscal years 2006 and 2007 for a number of VA major projects and capital leases that had been backlogged, some for a number of years. While relieved by this action, the IBVSOs remain concerned that VA's construction needs are not being fully addressed by Congress or the Administration. Also, while these projects have been approved through the authorizing legislation, it is important to note that, under law, they cannot commence without specific appropriations. Given that the VA is operating on a Continuing Resolution rather than its expected regular appropriation, at the time this *Independent Budget* is being published, VA is unable to proceed with this critically needed construction.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in fiscal year 2007, the administration recommended a paltry $399 million for major construction.

After that five-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

MAJOR CONSTRUCTION ACCOUNT

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for construction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

MAJOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES	$1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
TOTAL	**$1,602,000**

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MINOR CONSTRUCTION ACCOUNT

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its five-year capital plan in fiscal year 2008.

MINOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES/Non-CARES	$450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
TOTAL	**$541,000**

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Inadequate Funding and Declining Capital Asset Value:

The Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

RECOMMENDATION:

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that health care can be provided in safe and functional facilities long into the future.

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Increase Spending on Nonrecurring Maintenance:

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Pricewaterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the lifespan of VA's facilities. Examples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under Medical Facilities of the Medical Care Account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for health care, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

RECOMMENDATIONS:

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.

VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

High-Risk Buildings:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget veterans service organizations continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73 critical VA facilities that, based on Federal Emergency Management Agency definitions, are at a "moderately high" or greater risk of seismic incident. Twenty-four of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of health care and services as well as for cost-effectiveness, it also results in higher upfront project costs, which would require an increase in the construction budget.

RECOMMENDATIONS:

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections

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Establishing a Program for Architectural Master Plans:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

The Independent Budget veterans service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated, and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities, for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the

delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified needs, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program, and a more comprehensive examination, as part of a master plan, later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

RECOMMENDATIONS:

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

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Plan for Long-Term Care and Mental Health Needs:

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of long-term care and mental health programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."

Moreover, the commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

The Independent Budget veterans service organizations also concur with the CARES Commission's recom-

mendations that VA take action to ensure consistent availability of mental health services across the system to include mental health care at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

RECOMMENDATIONS:

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental health-care services, especially with the unprecedented current need for these services, and the likely tremendous long-term needs of our returning service members.

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Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs for different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air-conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long,

narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

RECOMMENDATION:

VA should develop a plan for addressing its excess space in nonhistoric properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

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Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/spinal cord dysfunction (SCI/D).

With the largest health-care system in the United States, VA has an advantage in its ability to develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designers, clinicians, staff, and management during the design process. These design guides, which are viewable on the Facilities Management web page, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in more than a decade, despite the massive transition of the VA health-care system from an inpatient-based system. *The Independent Budget* veterans service organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at SCI/D centers. It is important that these guides be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

RECOMMENDATIONS:

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

Preservation of VA Historic Structures:

The Department of Veterans Affairs (VA) extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations, or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget veterans service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108-422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage and encourage its use.

RECOMMENDATION:

VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

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Career and Occupational Assistance Programs

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, cumbersome, and unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to reduce or eliminate licensing requirements and employment barriers. We are encouraged by the continued emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) Service, former Department of Veterans Affairs Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E service. *The Independent Budget* continues to support the recommendations of the task force, and we look forward to continued implementation of these recommendations.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Vocational Rehabilitation and Employment Funding:

Congressional funding for the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) services must keep pace with veteran demand for VR&E services.

The VR&E program provides services and counseling necessary to enable service disabled veterans with employment handicaps to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service members and veterans recently separated from active duty. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) evaluates the average cost of placing a service-connected veteran in employment at $8,000 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the number of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges when they return home from the current global war on terrorism. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. At present funding levels, VR&E programs cannot keep pace with the current and future demand for VR&E benefits.

RECOMMENDATION:

Congress must provide the funding level to meet veteran demand for VA VR&E programs.

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VR&E Staffing Levels Inadequate:

Staffing levels of the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VA VR&E Service is charged with the responsibility to prepare disabled veterans for suitable employment and provide independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their entry into the program. However, VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily on VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service has been experiencing a shortage of staff nationwide because of insufficient

funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation and employment.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home To Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. It is imperative that VA increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services. The following facts further confirm these problems.

Currently, there are 89,000 veterans in the various phases of VR&E programs compared to 70,000 in FY 2000. This number is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Nineteen-thousand veterans have ended their participation in the VA rehabilitation program. Of these, 63.3 percent successfully completed the program, of which 48.9 percent ended with employment and 14.4 percent ended with achieving their goal of independent living.

For many years, *The Independent Budget* veterans service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain of concern, including the following:

- inconsistent case management with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads;
- declaring veterans rehabilitated before suitable employment is retained for at least six months; and
- inconsistent tracking of electronic case management information systems.

RECOMMENDATION:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demand of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce.

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Follow-up on Referrals to Other Agencies for Entrepreneur Opportunities:

Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure that the veteran's entrepreneur opportunities have been achieved.

VR&E has expanded its efforts toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, the Small Business Administration, and The Veterans Corporation and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneur opportunities and reassess their employment needs if they were not successful.

RECOMMENDATION:

VR&E staff must follow up with veterans after being referred to other agencies for self-employment to ensure that the veteran's entrepreneur opportunities have been successfully achieved.

VR&E Revision of Procedural Manuals:

The Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service must continue to revise its procedural manuals to keep current with changes in laws and regulations.

VR&E is currently working on revising its procedure manuals, which have been neglected for several years. Four of the seven chapters have been revised leaving three parts still to be updated. In addition to revising the content of the manuals, VR&E must establish an ongoing routine for revising its manuals to be consistent with changes in laws, regulations, and policies.

RECOMMENDATION:

The VR&E manual must be routinely revised to remain current with present as well as future changes in laws, regulations, and policies.

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VR&E Contract Counselors:

The Department of Veterans Affairs (VA) needs to improve the oversight of contract counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of contractors to supplement and complement services provided by VR&E staff. However, *The Independent Budget* veterans service organizations are concerned about the quality of services provided by contract counselors, which may be contributing to the problem of veterans dropping out of their VR&E program before completion or going into interrupt status in their rehabilitation plan.

A survey conducted by the Veterans Benefit Administration Office of Performance Analysis & Integrity conducted in 2003 supports this concern. The survey concluded that "VA staff counselors were consistently rated higher than contractor counselors on the majority of issues addressed by their survey." VA counselors were viewed to be more concerned about the individual's needs and goals and were likely to be more caring and compassionate.

RECOMMENDATIONS:

VR&E Service staff must improve the oversight of contract counselors to ensure veterans are receiving the full array of services and programs in a timely and compassionate manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology.

The VR&E Service must increase the success rate of their program above the current 67 percent to meet its goal of 80 percent by 2011.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

The VR&E Service needs to identify and address why veterans drop out of its VR&E program prior to completion or choose to interrupt their rehabilitation plans.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E Service should follow up with rehabilitated veterans for at least two years to ensure that the rehabilitation and employment placement plan has been successful.

VA needs to develop resource centers that focus on obtaining and maintaining gainful employment for veterans. The program needs to prepare veterans for interviews, offer assistance creating resumes, and develop proven ways of conducting job searches.

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Transition Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition-assistance workshops to separating military personnel through TAP and DTAP. These programs generally consist of a three-day briefing on employment and related subjects, and veterans' benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment (VR&E) Service representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). These numbers continue to grow as large numbers of separating service members are returning from the global war on terrorism. Many have been on "stop loss," prevented from leaving military service on their scheduled date, and they depart military service soon after their return. It is imperative that these soon-to-become veterans are not overlooked during their rapid transition to civilian life. Additionally, tens of thousands of National Guardsmen and Reservists have been called to active duty for the current conflict. No coherent program exists for them to receive transition services at demobilization. In some ways, they face even more difficult employment problems after being ripped from their civilian employment to serve the nation. Though protections exist, separating service members need detailed information on these protections and the benefits of service as well as information on other opportunities they may have available. *The Independent Budget* veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004 and expand them to Guardsmen and Reservists returning from combat.

The IBVSOs are encouraged that the VR&E Service is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans and we will continue to monitor the changes and progress in DTAP.

RECOMMENDATIONS:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for DTAP within the Veterans Benefits Administration to the VR&E Service and designate a specific DTAP manager.

The DOD should work closely with the DOL to ensure detailed transition services are provided at the demobilization station or other suitable site for demobilizing National Guardsmen and Reservists.

The DOD should ensure that separating service members with disabilities receive all of the services provided under TAP as well as the separate DTAP session by the VR&E Service.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active

duty unless separation is due to a service-connected disability when these services are mandatory.

The House and Senate Veterans' Affairs Committees should conduct oversight hearings regarding the implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

> Raise employer awareness of the advantages of hiring separating service members and veterans; facilitate the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and direct and coordinate departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

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Licensing and Certification:

Recently separated service members should have the opportunity to take licensing and certification examinations without a period of retraining.

Men and women of the armed forces acquire extensive knowledge and job skills, via military training and work experience, which are transferable to an array of civilian occupations. Along with technical proficiencies, service members offer intangible qualities like leadership skills and strong work ethics that are eagerly sought in the national job market as well as in other branches of government.

Yet an untold number of separating service members miss immediate opportunities to obtain good, high-paying jobs because of civilian licensure and certification requirements. Much of the lengthy and expensive training necessary for such certification is redundant to, and in some cases modeled on, military training.

This inefficient and costly waste of valuable human resources is unfair to veterans, an impediment to businesses that need skilled workers, and ultimately a burden upon the national economy due to delayed job creation, consumer spending, and unnecessary unemployment compensation insurance payments.

RECOMMENDATION:

To eliminate such artificial hurdles to employment in the private sector, the Department of Defense in partnership with the Department of Labor (DOL) should develop programs that track military training requirements and how they compare to those needed for licensing and certification in the civilian workforce. Additionally, the DOL should work with states and local governments and the private sector to enhance civilian awareness of the quality and depth of military training and to eliminate superfluous licensing requirements and employment barriers.

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Training Institute Inadequately Funded:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) specialists. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers, Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service offices, VA medical centers, Native American trust territories, military installations, and other areas of known concentrations of veterans or transitioning service members.

DVOP/LVER specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled and other veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER specialists' ability to assist veterans in their quest to obtain and maintain meaningful employment. Such topics include courses to develop the following:

- core professional skills,
- media marketing skills,
- case management skills,
- investigative techniques,
- quality management skills, and
- grants management skills.

Certain DVOP/LVER specialists may be required to participate in employment programs involving other state and federal agencies. The NVTI helps prepare DVOP/LVER specialists for their roles in such programs as the VR&E Service and the Transition Assistance Program (TAP). The NVTI curriculum also includes information and training on the Uniformed Services Employment and Reemployment Rights. The NVTI offers Department of Defense employees TAP management training through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans' programs, projects, and activities. *The Independent Budget* veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

RECOMMENDATION:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

Performance Standards:

Performance standards in the Veterans Employment and Training Service (VETS) system need to be uniform and consistent.

The enactment of the Jobs for Veterans Act (P.L. 107-288) has resulted in significant improvements in employment services to veterans and is showing a positive impact on veteran employment outcomes. However, while progress is being made, there are still no clear and uniform performance standards that can be used to compare one state to another or even one office to another office within one state.

In 2002, VETS began reporting performance outcomes that measured the "entered employment rate" and "employment retention rate" of veterans by state. However, the report lists percentages only, not actual numbers of veterans hired or served. Federal contractors must also file a "veterans hired" report annually. However, this report does not include all veterans employed and is only applicable to employers with federal contracts exceeding $25,000. The Bureau of Labor Statistics also has a number of reports available on the Department of Labor (DOL) website; however, none of them differentiate between disabled veterans, nondisabled veterans and nonveterans. It is clear that the Department of Labor needs to develop a standardized performance measure system and develop a centralized, national research database with this information.

Furthermore, despite these reporting requirements, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. VETS is authorized to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. However, this recognition is only for individuals and not entities. It would be practical if Congress would amend the Jobs for Veterans Act so entities (such as career one-stops) can be recognized and rewarded for exceeding the standards by providing them with additional funding.

In 2004 the VETS performance measures were applied to veterans served by the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff members as well. For several years, many have expressed a need for qualification standards to be put in place for both DVOP and LVER staff. In 2005 there was draft legislation proposed that would require the Secretary of the Department of Labor to establish such professional qualifications for employment in the two programs. While this concept is certainly welcomed and broadly supported, the legislation did not explain exactly how VETS would implement the new qualification standards.

The heart and soul of VETS efforts is the dedicated DVOPs and LVERs tasked with facing the employment challenges of hard-to-place veterans. For decades, DVOPs and LVERs have been the cornerstone of employment services for veterans. It is important for states to continue to be required to hire veterans for these positions. Part of this reason is that these individuals are veterans advocating for veterans. After all, DVOP and LVER staff are the front-line providers for services to veterans. They are the individuals who provide a smooth transition of service members from the military to the civilian workforce.

We must never lose sight of the fact that veterans continue to need the special job training and services that VETS provides within the Department of Labor. Shifting VETS to VA will not improve the employment and training needs of veterans. The DOL knows the job market and skills required to fill jobs beyond any other executive department. Furthermore, it is unclear as to exactly how VA would effectively run the program that so naturally suits the DOL. VA does not have the capacity or the assets to support employment programs. Therefore, the IBVSOs recommend that VETS remain a function of the Department of Labor.

RECOMMENDATIONS:

VETS should compile, and make available to the public, a state-by-state, standardized performance measure system on the hiring of veterans on all levels.

Congress should amend the Jobs for Veterans Act so that entities (such as career one-stops) can be recognized and rewarded with additional funding.

Congress needs to continue work on crafting legislation that will provide meaningful DVOP and LVER qualification standards, provide the Secretary with the authority and direction to implement the standards, and keep VETS within the Department of Labor.

The National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) honors veterans with final resting places that commemorate their service to our nation. *The Independent Budget* veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families despite funding challenges, aging equipment, and the increasing workload of new cemetery activations.

The NCA currently maintains more than 2.7 million gravesites at 124 national cemeteries in 39 states and Puerto Rico. At the end of 2007, 66 cemeteries will be open to all interments; 16 will accept only cremated remains and family members of those already interred; and 43 will only perform interments of family members in the same gravesite as a previously deceased family member.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the global war on terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 102,000 in 2006 to 117,000 in 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

NCA ACCOUNT

The Independent Budget recommends an operations budget of **$218 million** for the NCA for fiscal year 2008 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions:

1. to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites;

2. to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application;

3. to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries;

4. to award a presidential certificate and furnish a United States flag to deceased veterans; and

5. to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget. Volume 2 of the independent study provides a systemwide comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. Headstones and markers must be cleaned, realigned, and set. Stone surfaces of columbaria require cleaning, caulking, and grouting, and the surrounding walkways must be maintained. Grass, shrubbery, and trees in burial areas and other land must receive regular care. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The IBVSOs were encouraged that the NCA earmarked $28 million for the National Shrine Commitment for fiscal year 2007. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

FY 2008 NATIONAL CEMETERY ADMINISTRATION

(Dollars in Thousands)

FY 2007 Administration Request	$ 160,733
FY 2007 *IB* Recommendation	$ 213,982
FY 2008 *IB* Recommendation	
Administrative Services	$ 168,335
Shrine Initiative	$ 50,000
Total FY 2008 *IB* Recommendation	**$ 218,335**

RECOMMENDATIONS:

Congress should provide **$218 million** for fiscal year 2008 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.

Congress should include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

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The State Cemetery Grants Program:

Heightened interest in the State Cemetery Grant Program (SCGP) results in stronger state participation and complements the National Cemetery Administration (NCA) mission.

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The State Cemetery Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the Veterans Benefits Improvements Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial federal purchase of equipment. The program allows states in concert with the NCA to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $37 million for the SCGP for fiscal year 2008. The availability of this funding will help states establish, expand, and improve state-owned veterans cemeteries.

RECOMMENDATIONS:

Congress should fund the SCGP at a level of $37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

There has been serious erosion in the value of burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the federal government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

In the 108th Congress, the allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. *The Independent Budget* recommends increasing the service-connected benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected benefit from $300 to $1,270.

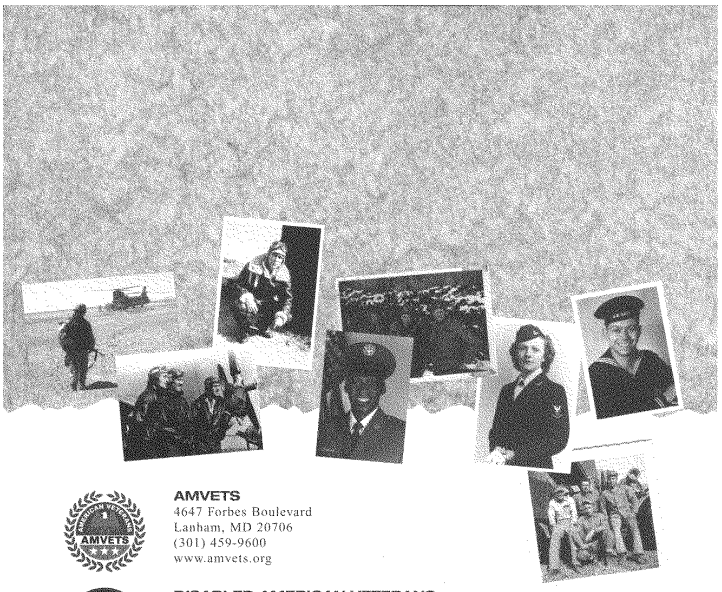
RECOMMENDATIONS:

Congress should increase the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

Congress should enact legislation to adjust these burial benefits for inflation annually.



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